INDEPENDENT LIVING:
THE PERSPECTIVES OF
OCCUPATIONAL THERAPISTS IN THAILAND

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Abstract

This research used focus groups to investigate the views of occupational therapists from contrasting geographic areas of Thailand on the concept and practicability of the independent living movement within a Thai context. In addition, convergent interviews were employed with individuals from a region where insufficient professionals for group formation agreed to participate. Emerging themes were around the issue of differences and similarities in the concept of independent living between Western and Eastern cultures. Rather than independent living promoting an individualistic culture in Thailand, interdependent living was seen to be likely to be more suitable for a collectivistic culture like Thailand. However, independent living, along with other constructs concerning activity and participation were deemed to have been integrated with values shared by the participants. According to their construction of responsibilities, the participants felt it was crucial to provide support for clients for independent living. Moving from an agricultural to an industrial society has caused changes in family structure in Thailand that have resulted in disabled people being pushed to live more independently. There do appear to be mechanisms within Thailand allowing independent living for disabled people to be made possible but it requires a period of time to address the barriers existing in disabled people themselves, their families, people in the community, physical environment, the Thai government and therapy professionals as well as financial barriers. To support independent living in Thailand, strategies for practice are suggested. Some strategies require cooperation and collaboration from other stakeholders in society. The client-centred and occupation-based models are viewed as being appropriate to form a frame of occupational therapy practice for promoting independent living and need to be augmented by community service, counselling and social skill, and knowledge for occupational therapists to be enabled to support independent living.
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List of Abbreviations

ADA American with Disabilities Act
APCD Asia-Pacific Development Centre on Disability
CBR Community Based Rehabilitation
DAN Direct Action Network
DDA Disability Discrimination Act
DPI Disabled People International
DPI-Thailand Disabled People International-Thailand
DPOs Disabled Peoples’ Organisations
DRC Disability Rights Commission
ICF International Classification of Functioning, Disability and Health
ICIDH International Classification of Impairments, Disabilities, and Handicaps
ILO International Labour Organisation
UK United Kingdom
UN United Nations
UN-ESCAP United Nations Economic and Social Commission for Asia and the Pacific
UNESCO United Nations Educational Scientific and Cultural Organization
USA United States of America
WHO World Health Organization
Chapter 1

Disability

This thesis is concerned with the study of the concept of independent living in relation to people with physical disabilities living with disability in Thailand and the role of occupational therapy as a profession in relation to that concept within its Thai context.

1.1 Outline of Thesis

To present the understandings of occupational therapists in Thailand concerning independent living, this thesis is organised as follows. Chapter 1 presents an introduction to the thesis which includes broad aspects of disability, and research questions and aims. Chapter 2 provides disability movement and the independent living concept. Chapter 3 show the independent living in the Thai context and, research on disability and independent living. Whilst the methodology used in this research in order to gather information from Thai occupational therapists is described in Chapter 4, expanding the theory of the research methodology is presented in Chapter 5. The details of the results of the study as well as the discussion are presented in the following five chapters. Chapter 6 provides the reader with an overview of the participants’ understandings and beliefs about independent living. It details their opinions on what independent living means to them and what they think about the degree of independent living that has been achieved. In Chapter 7, the participants’ opinions on the feasibility of independent living for disabled people in Thailand are explained. In addition, factors influencing the feasibility of independent living are described. Participants’ views about the practice guidelines used by Thai
occupational therapists to support independent living are expressed in Chapter 8 and 9. Whilst Chapter 8 discusses the support provided to disabled people in order to enable them to achieve the aims of independent living in an individual and group context, Chapter 9 details supports from occupational therapists for enabling disabled people to achieve the aims of independent living in a wider cultural context. In Chapter 10, appropriate models giving support to independent living are described. It also details some requirements for occupational therapists that are needed to deal with disabled people engaged in independent living. Chapter 11 presents the conclusions and the implications of the findings. It also discusses the limitations of the research and suggests further research.

The following sections will discuss the issue and concept of disability from both an historical and contemporary basis, the nature of the concept of disability’s importance to occupational therapy and will culminate in the research questions and aims.

1.2 Disability as a Concept

One of the ways to view disability is to describe it entirely in terms of features of an individual’s body. Narrowing the focus to the individual is to see a disability as a condition or a function judged to be significantly impaired relative to the usual standard of an individual belonging to the same group (Thomas 2007). During the last quarter of the twentieth century there was a strong challenge to viewing disability as an overt visible impairment or illness. An alternative concept of disability as a form of social oppression was put forward with restrictions on activity viewed as an imposition by society rather than features of an individual’s body. More recently, concepts of disability have edged closer together as with the concept held by Carol
Thomas (Thomas, 2007). Thomas (p. 73) emphasises “the social imposition of restrictions of activity ... and the socially engendered undermining of ... psycho-emotional well-being”. But in considering “psycho-emotional well-being” she recounts narratives of individual experiences and meanings obtained from “people with impairments”. That means she can still affirm that conditions are “socially engendered”, but she has edged away from an exclusively social oppression view. Bickenbach et al. (1999) discuss the views of the sociologist I. Zola about the limitations of an exclusively social oppression view (Zola 1989). Zola insisted that the “process by which the meanings of disability are negotiated” are social. But he also insisted on acknowledging “the near universality of disability ... including the biomedical dimensions”. Bickenbach et al. (1999) emphasize Zola’s reminder that in every culture “the entire population is ‘at risk’ for the concomitants of chronic illness and disability”.

1.2.1 Prevalence of Disability

Disabilities may occur during the course of a person’s life or may be present from birth. At present, the number of people affected is increasing due to the rise in chronic disease, injuries, accidents, violence and other causes such as ageing. It has been estimated that there are approximately 10 per cent of the world’s population, or 650 million people, living with a disability. The vast majority of such people live in developing countries (Lang 2006). From the report of the United Nations Economic and Social Commission for Asia and the Pacific (2010), approximately 400 million people with disabilities live in Asia and the Pacific region. To enable the reader to have a deeper understanding about disability, the following section comprises current
issues about disabilities including terminology, classification of disability, disability and poverty, and disability and culture.

1.2.2 Terminology

The issue of what to call the concept is an emotive one but it has to be faced especially by policy makers, service providers, anyone involved in assessment and disabled people's organisations. For example, in the United Kingdom (UK) at the time of writing, Manchester City Council affirms that “terminology is important because words reflect our attitudes and beliefs [but] “some of the terms we tend to use may not reflect how some disabled people see themselves. As such terminology such as “suffering from” “the disabled” and most emotive of all “handicapped” are in their list of terminology to be avoided. (Manchester City Council 2010). Attitudes which evoke sympathy, pity and even dislike or discrimination are implicit in expressions such as “afflicted with”, “victim of” and other expressions in the Manchester City list of terminology to be avoided.. How a person with a disability is referred to is important and needs to be discussed especially when placing the issues within a Thai context (see Chapter three).

The influential Publication Manual of the American Psychological Association (American Psychological Association 2001) states (para. 2.16) that “the guiding principle .... is to maintain the integrity of individuals [and] avoid language that equates persons with their condition”. Following that principle, in the United States of America (USA), results in the acceptable term being “people with disabilities”. This term is acceptable in many different contexts and avoids possibly offensive terminology (Carson 2009; Disabled Peoples' Association 2003). It is also similar to
the world view of liberal professionals that people or persons should come first and
descriptions of the impairment/disability should be used so that impairment/disability
is defined, but that the impairment does not act as a definer of or modifier of the
person. But there is a later style guide to which the American Psychological
Association refers called “Guidelines for Reporting and Writing about people with
disabilities” authored by the Research and Training Center on Independent Living,
University of Kansas (2008). It is made available at the American Psychological
Association website. This guide continues to recommend “people with disabilities”,
but warns (p. 2) that “some disability advocates use the term ‘disabled person’ instead
of “people with disabilities as part of a disability pride.”, the alternative term,
“disabled people”, is generally preferred by those within the disability movement
particularly in the UK who use it to make a political statement (Carson 2009, DEMOS
2002). Among disability activists within the disability movement, there are not
“people with disabilities”, but people who are disabled by society’s response to their
difference. Thus their objection to the term “people with disabilities” is that it has the
effect of linking people to their medical conditions and might be interpreted as
implying that the difficulties experienced by disabled people are a result of these
impairments (Carson 2009). Carson states that using “people with disabilities” under a
social model in order to refer to “people with social oppressions” amounts to self
contradiction

This research is about independent living based on sharing the fundamental
assumption of the social model that social structures are disabling, but accepting that
dimensions of the experience of impairment have to be considered as well. The
starting point can be referred to as a “qualified social model of disability”, because of
accepting the importance of dimensions of individual experience. For that reason, the use of the term “disabled people” is preferred throughout this research. It is also the terminology preferred by the cross-disability network “Disabled Peoples International” and by the United Nations (UN) Agencies [the International Labour Organisation (ILO); United Nations Educational Scientific and Cultural Organization (UNESCO); and the World Health Organization (WHO) who refer to Disabled Peoples’ or Persons’ Organisations (DPOs) in strategy documents such as WHO (2004).

1.2.3 Classification

Attempts to universalise the category "disabled" have encountered conceptual problems of the most fundamental sort and differing definitions have made it difficult to document the extent of the problem (Ingstad and Whyte 1995). In this section, two prevalent definitions of disability which have informed the legal and policy framework are described.

1.2.3.1 Medical Definition of Disability

In this perspective, disability is considered as individual pathology or a condition grounded in the physiological, biological and intellectual impairment of an individual. In 1980, WHO developed the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) and in 2001, the International Classification of Functioning, Disability and Health (ICF) in order to provide a framework for classifying the consequences of injuries and disease (World Health Organization 1980; World Health Organization 2001).
The ICIDH was designed to classify consequences of disease. Its terminology consisted of four concepts: disease or disorder, impairments, disabilities, and handicaps. Interactions between each component are illustrated in Figure 1.1.

According to the ICIDH, disease or disorder was identified as an intrinsic situation whilst impairments referred to "any loss or abnormality of psychological, physiological, or anatomical structure or function" (World Health Organization 1980). This meant that impairments were disturbances at the level of the organ. Disability was defined as "any restriction or inability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being" (World Health Organization 1980). This described disability as a functional limitation or activity restriction caused by an impairment. A handicap was defined as "any disadvantage for a given individual resulting from an impairment or a disability that limits or prevents the fulfilment of a role that is normal ... for that individual" (World Health Organization 1980). The classification of handicap was a classification of circumstances that placed an individual at a disadvantage relative to their peers when viewed from the norms of society. After using the ICIDH for a
while, some shortcomings were reported including insufficient attention to the role of the environment, overlap between dimensions, and lack of clarity about the causal and temporal relationship between each dimension (Gray and Hendershot 2000).

To address the problems inherent in the ICIDH, the ICF, also known as the ICIDH-2, was developed. The ICF has moved away from being a consequence of disease classification to become a component of health classification (World Health Organization 2001). It encompasses all aspects of human health and some health relevant components of wellbeing and describes them in terms of the health domain and the health related domains (World Health Organization 2001). The ICF acknowledged that people interacted with their environments, identifying 'impairments' (perceived problems in body function or structure), 'activity limitations' (difficulties in executing a task or action) and 'participation restrictions' (problems in functioning at the societal level) (World Health Organization 2001). The ICF model also valued personal and environmental factors that impacted an individual's ability to act and to participate (World Health Organization 2001). Table 1.1 and Figure 1.2 show an overview of the ICF and the interactions between its components.
Table 1.1 An overview of the ICF

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<td>Activities and Participation</td>
<td>Personal Factors</td>
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<td>Domains</td>
<td>Body functions and structures</td>
<td>Life areas (tasks, actions)</td>
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<td>Change in body functions (physiological)</td>
<td>Capacity Executing tasks in a standard environment</td>
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<td>Performance Executing tasks in the current environment</td>
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<td>Positive aspect</td>
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Disability
Table 1.1 summarises and Figure 1.2 depicts three dimensions of human functioning (impairments, activities and participation). Bickenbach et al. (1999) and Gray and Hendershot (2000) explain that they apply to people across the age span and around the world. Figure 2 has no arrows pointing directly from one of the three dimensions to the other and they are at the same level in the diagram. There is an assumption that they are co-equal, but no assumption such as impairment leading to limitation of activity or, in turn, to restricted participation. In other words, there is no "disablement syndrome". There is neutrality with respect to background health condition and it is inappropriate to characterise disablement in inherently negative. At the time of writing, WHO is promoting the use of the ICF in order to provide a standard vocabulary and unified conceptual framework for the description of health states of individuals as well as a given population. Under the ICF classification, the notions of 'health' and 'disability' were put in a new light. It acknowledged that everyone could
experience a decline of health and thereby experience some disabilities (World Health Organization 2002). It also allowed for framing research questions and showed promise in bringing client centred care in practice much closer to realisation. It is referred to as a “bio-psychosocial model” and has been used in advocating that rehabilitation become more holistic (Iwama 2006a). However, Bickenbach et al. (1999) admit that the classification is criticised for being too close to a medical and individual-centred concept of disability, and failing to adequately classify the interaction between societal conditions or expectations and unique circumstances of disabled people.

1.2.3.2 Social Definition of Disability

The change in the understanding of disability from an individual pathology to a social construct is strongly reflected in the way UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1993 define disability (Hurst 2004). According to these rules, physical, intellectual or sensory impairment, medical conditions or mental illness may cause people to be disabled. Following the distinction made between disability and handicap (United Nation 1993), a handicap is considered a loss or limitation of opportunities to take part in community life on an equal level with others (United Nation 1993). The purpose of this distinction is to emphasise the focus on the shortcomings in the environment and in many organised activities in society that handicap a disabled person (United Nation 1993). Thus, it can be concluded that the conception of Standard Rules is more concerned with how society is structured than on the individual disabled person’s right to humanity (Hurst 2004).
Williams (2001) welcomes changes in the medical understanding of disability as an individual pathology to giving attention to the social and physical environment. But such changes seem to remain at a distance from conceiving of disability as a social construct. Nevertheless Williams sees the move by some disability activists to “more systematically pluralist approaches to disability” as bringing contrasting concepts of disability closer together. It has been suggested in this chapter that the kind of thinking that led to the UN rules could be an example where the change in concepts of disability were translated into UN policy.

1.2.4 Disability and Poverty

It is widely accepted that disability and poverty are linked. This link can be seen everywhere in the world both in developed and developing countries. In the recent studies of Nagata (2007) and van Kampen et al. (2008) about the existence of a relationship between disability and poverty, several types of relationship between disability and poverty have been described. Firstly, disability caused stigma, and therefore to exclusion which subsequently made people more vulnerable towards poverty, especially in developing countries of Asia (Nagata 2007; van Kampen et al. 2008). Social exclusion was considered as a form or consequence of discrimination that came with social values concerning impairment. It appeared to be the essential link between disability and poverty. Secondly, disability might exclude people socially and economically, which makes them poorer and gives them even less access to care, which in turn may aggravate their disability. Next, it was suggested that disability had an impact on a person’s ability to work and earn a living. This resulted in them becoming poorer after they were disabled.
Therefore, to break the vicious circle of disability and poverty, it was necessary to look more into the linking determinants or aggravating factors and should largely focus on reduction of stigma, combating discriminatory practices and empowering disabled people. It was suggested that strategies and interventions to counteract the linking determinants should be operated from a social or human rights model of disability (Nagata 2007; van Kampen et al. 2008).

1.2.5 Disability and Culture

Since the International Year of Disabled Persons in 1981 and the United Nation’s Decade for Disabled Persons from 1983 to 1992, disability has been put into a global context. Many questions have been raised about how to understand and deal with disability in a multicultural world. To what extent can programs developed in one place be successfully implemented elsewhere? What kinds of cultural and social differences matter and how can they be taken into account? (Whyte and Ingstad 1995) This section presents some issues relating to disability and culture, and relates this to the very western and political view of disability promulgated by the disability movement in the USA and the UK.

According to the social definition of culture, culture is defined as a packet of signs, symbols, values, and beliefs that is passed from generation to generation within a society (Hammell 2006; Loveland 1999). People learn what is appropriate and acceptable within their own culture and may view their way of doing things as the only correct way (Loveland 1999). This attitude is called ethnocentrism which is common in all of the world’s cultures. To enable cross-cultural communication and interaction cultural relativism has to be accepted, and ethnocentrism rejected. An
emphasis needs to be placed on understanding and tolerating other cultures in their own context (Loveland 1999). Culture has two major components: material and non material (Loveland 1999). Whilst the material culture encompasses all of the more easily seen parts of culture such as architecture, clothing, food, the nonmaterial is about values, beliefs and attitudes that people usually learn early in life and only change them with difficulty. The latter is abstract and often difficult for those outside the culture to understand (Loveland 1999). In a rehabilitation context, beliefs about the causes of disability and beliefs about the roles of disabled people, families and health professionals can be classified as part of the nonmaterial culture whilst facilities, technology and rehabilitation equipment are a part of the material culture. Occupational therapists have always been very involved in the context of the person trying to carry out their occupations. This is overtly seen via the occupational therapist’s concern with adapting the physical environment to enable the disabled person to function more easily whilst carrying out occupations. It is also, however, seen in terms of the local, social environment (Kielhofner 2002) and the wider political, cultural and institutional environment (Townsend and Polatjko 2007). Thus the environment within which the disabled person is expected to carry out their occupations is of paramount importance to the occupational therapist. Within this study, therefore, it is important to consider not just the physical issues of disability, but also how that disability is perceived in society and how society enables it disabled citizens to function occupationally.

Political conceptualisations of disability which suit one nation, may well not be appropriate in another potential influence on the way in which disability is conceptualised is often that of religious beliefs (Loveland 1999). In many cultures,
people believe that illness, accidents, disability, and even death are supernatural punishments for the misbehaviour of either the patient or a member of the patient’s family (Loveland 1999). If that is the case, taking a patient’s history entails more than recording relevant medical information. An examination of the psychosocial background of the patient’s relatives and ancestors should be undertaken. In addition, health professionals must respect such beliefs and be aware that patients and families may not discuss them with health professionals, especially if these health professionals do not appear to share these beliefs (Loveland 1999).

Not only religious belief, but values and norms also have an impact on rehabilitation. In Western culture, people’s values emphasise the importance of the individual and the ability of an individual to affect their future through hard work (Loveland 1999). Self is defined as centrally and focally situated in the centre of the universe, and also understood to be rationally separate and superior in power and status to the environment and nature (Iwama 2006a). Well-being is constructed to be contingent on the extent to which the self can act on and demonstrate ability to control one’s perceived circumstances located in the environment (Iwama 2006a). Independence as an ideal is celebrated as if there was a common world view and value pattern. Thus, much mainstream rehabilitation ideology derives from Western social contexts (Iwama 2006a). On the other hand, in Eastern culture, people take a different view of the relation between the group and the individual (Loveland 1999). Self is not central nor unilaterally empowered but rather construed to be just one of many parts of an indivisible whole (Bellah 1991). The individual is inseparably embedded in his or her environment (Iwama 2006a). Health and disability states are also not believed to be an individual-centred matter. Life circumstances are dependent on a broader whole,
determined by a group of factors or elements located both within and outside the physically defined body (Iwama 2006a). Therefore, conceptual models of rehabilitation that are based on an understanding of a central individual separate from the environment may not adequately explain experiences of disability, health and rehabilitation for an individual who is situated outside mainstream Western social norms (Loveland 1999).

As culture is obviously an issue in how disability is seen, it is important to investigate the literature of disability and relate it to its cultural origins. It is also equally important before adopting a conceptual model for dealing with the issues of disabled people such as independent living, to examine individuals’ views of disability and the independent living concept. In a previous study (Panyamee 2005), I investigated this from the perspective of physically disabled people in Thailand and now wished to investigate it from the perspective of rehabilitation staff in the form of occupational therapists, of which I am one. This thesis, therefore, explores Thai occupational therapists' opinions and understanding of the issue of independence in physically disabled people. It intends to identify the extent to which their opinions and understanding support the independence of physically disabled people. As the Thai government intends to create a strategy for promoting independence in Thai disabled people, the views of the occupational therapy community could be used to influence such a strategy and relate it to the aspirations and concepts inherent in the ICF with respect to promoting independence in Thai disabled people. Thus this study’s research questions and aims are as follows:
1.3 Research Questions

This study explores Thai occupational therapists’ opinions and understanding of the issue of independence in physically disabled people with the following questions:

1. What does independent living mean to Thai occupational therapists?
2. Is it possible for Thai disabled people to live independently in the views of occupational therapists?
3. What support is needed and how should it be offered in order to enable disabled people to live independently?
4. What are the appropriate models of practice for Thai occupational therapists to use for supporting independent living?

1.4 Research Aims

In accordance with the above mentioned questions, this research aims to:

1. Investigate the understanding and beliefs about independent living in Thai occupational therapists.
2. Explore Thai occupational therapists’ opinions on the feasibility of independent living for Thai disabled people.
3. Investigate strategies for practice for Thai occupational therapists which enable them to provide support for disabled people engaging in independent living.
4. Identify appropriate models of practice for Thai occupational therapists in order to enable them to provide support for disabled people engaging in independent living.
Chapter 2

The Literature of the Disability Movement Related to the Concept of Independent Living.

This chapter will review the literature of the disability movement and will be followed by chapter three which will relate it to the Thai context and Thai occupational therapy.

According to Gough (2007), a number of common stages are described in systematically reviewing literature. These include:

- Specification of the question, the conceptual framework and method of review (though this may not be pre-specified in iterative reviews with emergent methods)
- Definitions of studies to be considered (inclusion criteria)
- A strategy for identifying such studies (search strategy and screening)
- Describing the research field (systematic mapping)
- Quality and relevance appraisal
- Analysis and synthesis
- Communication of review findings
- Interpretation of findings for different needs
- Implementation of interpreted findings for different needs

Taking Gough into account and after examining Boaz et al. (2006), Walters et al. (2006) and Atkins et al. (2008), a plan for reviewing the literature was devised. It is
summarized in Table 2.1. The databases consulted and the numbers of studies are listed in Table 2.2

Table 2.1 Stages of the literature review

<table>
<thead>
<tr>
<th>Stage</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>The strategy concerning purpose was an iterative one. As a starting point it was decided to consider reactions to classifications of disability by disabled people and professionals. Then consider the applicability and transferability of independent living concepts beyond Western culture where notions of markets as well as rights seem individualist to people acculturated in a more collective culture.</td>
</tr>
<tr>
<td>Inclusion criteria</td>
<td>Independent living for disabled people.</td>
</tr>
<tr>
<td>Search strategy</td>
<td>Text words included “independent living” disabled or disability, and Thailand</td>
</tr>
<tr>
<td>Quality appraisal</td>
<td>An explicit theoretical framework, clear aims and objective, clear research design, trustworthiness of data analysis</td>
</tr>
<tr>
<td>Synthesis approach</td>
<td>Key findings as described by authors. Research questions for further investigation of disability classification and the independent living concept to be framed by the reviewer</td>
</tr>
<tr>
<td>Implementation</td>
<td>Practitioner views about classifications and concept applicability and transferability to be investigated in Thailand in the light of the reviewer’s previous research with service users.</td>
</tr>
</tbody>
</table>
As can be seen from the search of the databases using the broad categories described above, fewer and fewer literature sources were discovered once Thailand and disability were included. The literature which was uncovered has been used...
consider the broad concepts they discussed and these concepts are critiqued in the following sections.

2.1 Disability Models

Different people conceptualize the phenomenon of disability differently. Accordingly conceptions regarding disability have undergone changes from time to time, from place to place, and from person to person. The following section discusses an understanding of the different models of disability which have evolved from disability and disability movements worldwide.

2.1.1 The Moral Model of Disability

The moral model probably represents the oldest and also the most pervasive framework for understanding disability (Hammell 2006). It is also evident in all the major religions such as Christianity, Hindu, and Buddhism. It responds to a human need to explain why bad things happen by attributing a cause for impairments. Within this model, impairments are explained as the result of sin, witchcraft, the 'evil eye', and the wrath of God or an ancestor's anger (Hammell 2006; Miles 1999).

When considering the consequences of the moral model, the model is particularly burdensome for disabled people (Kaplan 2000). It has been particularly influential in informing and justifying widespread discrimination against disabled people. Firstly, they are normally prohibited from assuming leadership roles within their faith communities and may be limited in their worship because impairments are viewed as evidence of an inherently sinful person (Hughes 1998). For example, some religions such as Hinduism and Buddhism have laws that have excluded disabled people from
their right of inheritance and from becoming priests, kings, monks or doctors (Miles 1995). In addition, the thought that impairments are deserved leads easily to mocking, banishment, abuse, and pity (Hammell 2006). For instance, the belief that disabled people are ‘pitiful’ underpins the concept of charity or alms-giving (Hammell 2006). This does not encourage changing the circumstances of disabled people to become people with equal opportunities (Hammell 2006). Furthermore, by explaining disabled people’s oppression as a form of punishment, moral and ideological justification for infringing disabled people’s rights are provided (Vasey 2004). The traditional belief that impairments constitute a form of divine punishment often leads to guilt and shame of the entire family. This results in disabled people being hidden and excluded from any chance at having a meaningful role in society (Kaplan 2000; Loveland 1999). They have no right to live in mainstream society. They are not entitled to any right to education, social life and employment available other members of the society. Neither government nor society can be viewed as being concerned with the problems faced by them (Bhanushali 2007).

2.1.2 The Tragedy/Charity Model

The tragedy or charity model is driven mainly by the emotive appeals of needing charity (Bhanushali 2007). This model treats disabled people as victims of circumstance. Disabled people are viewed as people who need care, are not capable of looking after themselves or managing their own affairs, and need charity in order to survive. It relies heavily on the charity and benevolence of able bodied people rather than justice and equality. According to this model, disabled people are excluded from social arrangements and services in public domain by relief measures creating an army of powerless individuals, without any control or bargaining power, depending
either on state allocated funding or benevolent individuals (Bhanushali 2007). This model asks for social support mechanism for the benefit of disabled people. Initial efforts of many governments and individuals were based on this model, in which a government allocates large chunks of funding for the welfare of disabled people as direct benefit or support to voluntary organisations. At the same time non-governmental organisations working for the benefit of disabled people also rely on donations and government grants (Bhanushali 2007).

2.1.3 The Medical Model of Disability

The medical model is recognised as "modern" medicine (Kaplan 2000.). It was developed in the 19th Century along with the enhanced role of the physician in society. According to the medical model, disability is often used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and various types of chronic disease (Williams 2001). It focuses on the individual body within which illness is situated although illness may arise from sources in the environment surrounding the individual person. Under the medical model, disabled people are in the sick role and are expected to come under the authority of the medical professional in order to get better (Kaplan 2000; Williams 2001).

In relation to rehabilitation, the medical model has traditionally underpinned many of the rehabilitation professions (Hammell 2006). Their assessment and intervention focuses on the functional limitations, the effect of these on activities of daily living and they attempt to provide prevention, cure, or care for disabled people (Williams 2001). However, the medical model assumes that there is an optimal level of human
functioning. Therefore, the application of treatments under medical and rehabilitation services aims to enable individuals to overcome their functional deficits and appear in a manner as near to normal as possible (Hammell 2006). In addition, disabled people are expected to adapt themselves to a society designed to meet the needs of the dominant population. This means that there is no requirement for society to change to suit all its members. Therefore, it is impossible for the medical model to identify social problems rather than an individual’s problem (Hammell 2006). Furthermore, the model privileges expert biomedical knowledge (Reynolds 2004). This results in clients not being involved in making decisions about treatment. Individual experience, values and goals also seem quite irrelevant to decisions about treatment, care and support (Reynolds 2004).

2.1.4 The Social Model of Disability

The social model of disability arose out of the experiences of disabled people (Hammell 2006). It was originally articulated by disabled activists and has been embraced, debated and promoted by the disabled and disability theorists. According to the social model of disability, disability is viewed as socially constructed and caused by socially and physically disabling environments rather than being the result of individual impairment (Barnes 2004; Mackelprang and Salsgiver 2001; Oliver 1999). Under this model, people are disabled when they are viewed by society as a minority group and, consequently, are devalued and discriminated against (Mackelprang and Salsgiver 2001). It is an holistic approach that explains specific problems experienced by disabled people in terms of the totality of disabling environments and cultures including inaccessible education, information and communication systems, working environments, inadequate disability benefits,
discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images in the media – films, television and newspapers (Barnes 2004). In order to reduce the disabling impact of society, the social and physical barriers in societies’ resources need to be removed (Mackelprang and Salsgiver 2001) and this requires social action (Oliver 1990). Thus, it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of disabled people in all aspects of social life (Oliver 1990). Furthermore, the social model proposes that disabled people have the right to and the responsibility for control over their own lives (Mackelprang and Salsgiver 2001).

2.1.5 Human Rights Model

Over the past two decades, the perspective from an approach motivated by charity towards disabled people has been dramatically shifted to one based on rights. According to the human rights model, all human beings irrespective of their disability have certain rights (Bhanushali 2007; Rioux and Carbert 2003). This model builds upon the spirit of the Universal Declaration of Human Rights in 1948 (Bhanushali 2007; Rioux and Carbert 2003). It emphasises that disabled people are equally entitled to rights as others. Disabled people are viewed as subjects and not as objects. This model locates the problem outside disabled people and addresses the manners in which the economic and social processes accommodate the differences of disability or not, as the case may be (Bhanushali 2007). It can be viewed as having a similar philosophy to the social model of disability, but with a more radical, political rights based approach.
2.2 Disability Movements

The previous section discussed disability models, provided evidence that societal perceptions of disabled people have changed over a period of time from being seen as sin or punishment by God for wrong doing in a previous existence to being recognised as citizens who need the same rights and opportunities as others instead of pity and charity. Disability movements worldwide have a great role to play in this transformation. What follows is a presentation of the development of disability movements in developed and developing countries.

Overall the disability movement emerged in the 1960s. In the USA, the biggest changes within the disability rights movement came with the civil rights movements when disabled people wished to gain political consciousness as African Americans, women and other social minority groups (DeJong 1979; Oliver 1996). In the early 1970s, they lobbied Congress to put civil rights language for disabled people into the 1972 Rehabilitation Act. Even though, the Act was vetoed by President Nixon, a revised 1973 Rehabilitation Act was passed after a group of disabled people marched on Washington. It was the first time in history that the civil rights of disabled people were protected by law. Another movement parallel to the disability rights movement was a movement in the 1970s to access to educational services for disabled children and youth. Consequently, the Education for All Handicapped Children Act (P.L. -94-142) was passed in 1975 to ensure equal access to public education for disabled students (VSA arts [no date]). Despite changes in rehabilitation and education law, disabled people did not achieve broad civil rights until the enactment of the American with Disabilities Act (ADA) in 1990 (Harrison 2002). This landmark federal anti-discriminations law ensures equal access to employment opportunities and public
accommodations for disabled people (Harrison 2002). With this Act, Congress identified the full participation, inclusion and integration of disabled people into society as a national goal.

Similar to the USA, the disability movement in the UK also made great progress on disability. It emerged with the fact that disabled people were not sharing the wealth of the abundant society (Oliver 1997). Therefore, a national disability income was developed to ensure that disabled people were able to share in the affluence of the time (Oliver 1997). This then led to the emerging movement in the 1970s for questioning what might be called the incomes and oppression approaches to disability (Oliver 1997). The 1970s was the time that the disability movement altered its stance toward a more rights based approach (Oliver and Barnes 2006). In the 1980s, many organisations controlled and run by disabled people at local, national and international levels were established (Oliver 1997). These organisations constituted disability movement with the potential to exert a powerful influence on political and social change (Oliver 1997). In addition, a transformation in the understanding of disability emerged in this era. The particular importance was the redefinition of disability by Britain’s Union of the Physically Impaired Against Segregation (UPIAS) and the development of the social model of disability (Barnes 2003).

During the 1990s, disabled people in the UK were willing to take to the streets and participate in peaceful direct action. Formed in 1992 the Direct Action Network (DAN) co-ordinated these activities and also kept the pressure on government by targeting particular parliamentary constituencies for mass demonstrations (Oliver and Barnes 2006). All this made the passage of the Disability Discrimination Act (DDA)
in 1995 (Oliver and Barnes 2006). In the late 1990s, the combination of government and the big charities have successfully adopted the big ideas of the disabled people’s movement, usurped its language and undertaken further initiatives (Oliver and Barnes 2006).

Even though, it seemed that the UK government had become more willing to listen to the voice of disabled people and disabled people’s goal pertaining social inclusion could achieve finally, some activists did not share this view (Finkelstein 2007; Oliver and Barnes 2006). They stated that disability movement in Britain was in decline did all go wrong by the middle of the 1990s (Oliver and Barnes 2006). They realised that national organisations controlled by disabled people were weakened as traditional charities after being combined with the government. They criticised the establishment of Disability Rights Commission (DRC) as the non-accountable organisations to disabled people. They criticised what they saw as a narrowly legalistic, rights based approach to disability politics, which became and ended in itself. In their opinion, this tended only to benefit those people who worked in the rights industry and led to the professionalisation of disability rights. To solve this situation, a pluralistic approach to disability politics in order to better acknowledge disabled people’s diverse views was suggested (Shakespeare 2006). However, it was difficult for disabled people to be associated with other impairment groups (Deal 2003). Therefore, linking between different groups of disabled people was suggested (Baresford 2006). Besides, it was emphasised that disabled people should be part of a far wider struggle to create a better society for all rather than singular focus on disability as a rights issue (Oliver and Barnes 2006). It was also argued that the issues of cultural, communication and physical access should be taken into account (Baresford 2006).
For countries that were less developed, progress on disability made by disability movements differed between each country. The differences might be a result of the limitation in disabled people's lives, the extent to which disabled people created serious movements, and government's effort and intention in using their legal frameworks to support disabled people. For example, during the 1980s and early 1990s disabled people in South Africa were part of the liberation struggle (Rowland 2001). They made several violent protests in order to being recognised as a member in society, request income generation through self-help, and mobilise disabled people to claim their rights by using a famous slogan “Nothing About Us Without Us” (Rowland 2001). Consequently, they shared in the fruits of a new democracy when Nelson Mandela was elected to be a president (Rowland 2001). This was a landmark victory for South African Federation of Disabled People. In contrast, disability movement in India was reported to have success in changing the approach towards disability from moral model to charity model but being limited to achieve in the direction of human rights model (Bhanushali 2007). Disabled people in India were reported have limited access to available services and facilities than their non-disabled peers. Consequently, they are the least nourished, least healthy, least educated and least employed citizens of that country. They are subject to a long history of neglect, isolation, poverty, deprivation, charity and pity. Even though there were adequate legal frameworks in order to address the issue of disability, their legislative provisions were not percolating to disabled people because of lack of awareness (Bhanushali 2007). This was because the policies and schemes of government are guided by the medical model rather than the human rights model (Bhanushali 2007). Even voluntary organisations working for disabled people themselves are not aware of the legal
provisions available to assist disabled people (Bhanushali 2007). Rather than the human rights model, these organisations were reported to run their interventions based on the charity model (Bhanushali 2007). Therefore, it was difficult for the disability movement in India to move forward to the rights based approach.

In conclusion, disability movements worldwide had long attempted to change the perception on disability from being viewed as a tragedy which required the assistance of charity to being recognised as a member of society who had the same rights as others. Collective efforts on the part of disabled people, their advocates, organisations, government and society at large are required to create real world where abilities and disabilities are not seen on the basis of physical or mental impairment but disability is seen as diverse abilities.

2.3 Independent Living

Independent living (IL) for disabled people has been defined as a social movement (World Institute on Disability [no date]). It is based on the social model of disability where disability is socially constructed and is caused by socially and physically disabling environments rather than being the result of individual impairments (Mackelprang and Salsgiver 2001; Oliver 1999). It was a concept originated from United States of America (USA) since 1960s (Crewe 1979; Morris 1993). The following paragraphs provided readers with an overview of independent living. These included the definition of independent living and the models of independent living which there were several meanings to the term in common use. In addition, the philosophy of independent living and a relative concept were detailed.
2.3.1 What Does Independent Living Mean?

Even though independence is considered to be a principle goal for disabled people who live in the community, the definition of independence among people does not have a fixed meaning. One definition of independence is being able to undertake any tasks alone or without direct help (Helgoy et al. 2003). This definition places a strong emphasis on being "normal" and implies that people should have the ability to undertake their own daily tasks. It is found that health professions tended to define independence as the ability to perform self-care activities without help provided (Reindal 1999).

However, the definition of independence mentioned above is dissimilar the definition of independence in the way of independent living. From literature, the notion "independent living" for disabled people has been discussed at three levels including a descriptive analytic level, at a critical level, and at a visionary level (the disability movement) (Hasler 2003).

At the descriptive analytic level are definitions such as that of the UK National Centre for Independent Living which published a leaflet highlighting choice and participation.

"The essence of Independent Living is the freedom to make decisions about your own life and to participate fully in your community."
or, highlighting social relations,

"...Independent Living means that disabled people want the same life opportunities and the same choices in every day life that their non-disabled brothers and sisters, neighbours and friends take for granted."

At the level of critical debate, independent living has been judged to be an individualistic philosophy, suiting a market model of services and individual distributive justice avoiding the issue of power except in the instance of individual exchange (Williams 1983). Woodill (2006) took on board the criticisms by Williams, and proposes a more community oriented notion of independent living. It involves partnerships and relationships with other human being at various degrees of intimacy, based on common interests and shared experiences. Choice, control and individual achievement are balanced by acceptance, receiving, and community service by each member of the community (Woodill 2006).

At the visionary level are critiques of definitions of disability and the insistence that disability is a social construction or creation, that it can be socially redefined and the environment which creates disability can be modified to remove barriers to activity and participation (Oliver 1990; Oliver, 1996).

At the visionary level is the UN Convention on the Rights of Persons with Disabilities which was adopted on 13th December 2006 by means of resolution A/RES/61/106. The purpose of the convention is stated as “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (United Nation, 2006).
At the visionary level as well are the goals of the disability movement. Angharad Beckett (2005; 2006) argues that it makes sense to think of a disability movement because there is a uniting principal pulling together different groupings and organisations in spite of great difficulty in deciding which disability groups or disabled individuals should be regarded as comprising such a movement. She concedes that there are many and various strands in the thinking and campaigning of the movement. At the same time, they can be seen to be united on the basis of a shared understanding of the need to challenge pre-conceived ideas about disability and they are united in their view that we live in a ‘disabling society’.

In summary, at the descriptive level independent living may be discussed as a progression beyond assisted living. Then at the level of critical debate “independent living” is proposed as a philosophy. Then at the visionary level the debate concerns whether holding a philosophy about enjoyment of rights and respect goes far enough. However, all of these are viewed within Western culture. Therefore, it raises a question how independent living for disabled people is defined in the countries outside western culture.

2.3.2 The Philosophy of Independent Living and Relative Concepts

When the philosophy of independent living was described in this section, the study took the concept of independent living as used by the grass-roots “consumer” movement founded and directed by disabled people.

The philosophy of independent living is laid into two levels: simple and comprehensive. Basically, the philosophy behind independent living promotes
individual power and a belief in a person's ability to make decisions and take actions that affect the course of his or her life. It aims to empower individuals to accept responsibility for their own lives (Crewe 1979; Morris 1993). It is associated with the concepts of freedom, self-determination, and individual autonomy (Crewe 1979; Evans 2002a).

But independent living is more than an individual aim. It encompasses a change in social relations. It is both a philosophy and a practical approach bringing disabled people together to work for civil and human rights (Hasler 2003). It promotes equal opportunities for everyone as well as self-determination for themselves. To do this, most centres of independent living consider the provision of support services such as personal assistance services to be a key prerequisite to civil right. This resolution locates independent living firmly within the framework of human rights in order to ensure that disabled people can exercise their human and civil rights, equally with non-disabled people. In addition, the independent living movement considered that government must pass legislation in order to protects the human rights of disabled people, including equalisation of opportunities in order to enable disabled people to full and equal participation in society as enshrined in the UN Universal Declaration of Human rights and the UN Convention on the Rights of People with disabilities (Mégrét 2008; United Nation 2006).

Independent living is not an individualistic philosophy that focuses on supporting individual people and ignores the wider social and economic pressures facing disabled people (Hasler 2003). According to the social model underpinned the philosophy of independent living, achieving the social aims of independent living requires collective
action since the system they live in puts too many obstacles in the way. Even though, the corner stone of independent living philosophy is control and choice, systems advocacy in order to have some choices for disabled people is ultimate importance.

In addition, the philosophy of independent living focuses on using inclusive approach in order to address all aspects of exclusion disabled people face (Hasler 2003). Disabled people are a disadvantage group. They confront with poverty and unemployment. They are restricted and excluded from participation in the mainstream of social activities. Using inclusive approach, the barriers disabled people face are focused on and dismantled. Rather than requiring rehabilitation in order to exist in an inaccessible society, the independent living movement asks society to adapt in order to accommodate the disabled people (Hasler 2003). This is central to independent living philosophy.

Another principle of independent living philosophy is cross-disability (World Institute on Disability [no date]). It is necessary to ensure that all disabled people with visible and invisible disability have opportunity of independence (Kim and Fox 2004; World Institute on Disability [no date]. This means reaching out across impairment groups, learning about each other’s needs and wishes. Segregation and institutionalisation should be condemned. They are not only direct violation of human rights; they are also preventing disabled people to know each other.

The philosophy of independent highlight that disabled people should be seen as ordinary people. Being ordinary people means challenging traditional attitudes to disabled people as medical cases and objects of charity and care, pity and protection.
Disable people who are seen as in need of care or as vulnerable are not seen as capable of self determination and full citizenship. Peer support helps disabled people to develop self belief as individuals and to work together as a group to challenge unhelpful attitudes. Peer support is a practical expression of the philosophy of independent living (World Institute on Disability [no date]).

In conclusion, the philosophy of independent living is both simple and comprehensive. It covers the whole range of practical solutions to disabled peoples inclusion. These solutions only come about if disabled people organise themselves to work for political changes to bring about human and civil rights. These rights need to be enshrined in law at both national and international level. It also requires complicated changes including dismantling the apparatus of welfare and creating new sorts of support. However, the philosophy of independent living is based on individualistic culture. It is necessary to examine whether the philosophy of independent living would be changed when it is implemented in collectivistic culture like Thailand.

From the philosophy of independent living mentioned above, Community Based Rehabilitation (CBR) was considered to be a relative concept of independent living. Both CBR and independent living had some aims in common including help meet the needs, defend the rights, and promote the full integration of disabled people (Werner 1998). They were a response to the discrimination, limited opportunities, inadequate services, and the need for self-determination that most disabled people experience in the world today (Werner 1998). Even though, both of them were run in the community, they had different origins, strength, and weakness. While the independent
living movement was started from the bottom up by disabled people themselves, CBR, as an international initiative, was launched by idealistic rehabilitation experts working with the WHO (Werner 1998). Independent living’s strength was social movement for equal opportunities, led by disabled activists. However, its weakness is that it is largely a middle-class movement that often leaves out the poor (Werner 1998). For CBR, its biggest strength is that it tried to reach all disabled people, especially those who are poorest and in greatest need (Nakanishi 2007). However, rather than leaders, organizers and decision makers, disabled people are often treated as objects to be worked upon (Werner 1998).

2.3.3 Movements Related to Independent Living

In addition to being framed by a social model of disability, the independent living movement was influenced by other complementary social movements which included civil rights, consumerism, self-help, demedicalisation, and deinstitutionalisation (Basnett 2001). All of which were relevant to a western culture at the time and place in which they developed.

2.3.3.1 Civil Rights Movement

The civil rights movement of the 1960s in the USA had a great impact on the racial minorities it sought to benefit (DeJong 1979). It fought first, for basic civil rights and then for benefit rights. In the initial stage, the civil rights movement focused on the need for African Americans to achieve basic civil rights in order to vote, hold elective office and be tried by a jury of one’s peers (Oliver 1996). After these rights were gradually achieved, the movement became concerned with benefit rights, including the entitlement to income and medical assistance benefits, educational benefits, and
other entitlements (DeJong 1979). Therefore, the civil rights movement had an influence on other groups of people experiencing discrimination such as women and disabled people (Oliver 1996) who, subsequently, became aware of their rights and how they were being denied (DeJong 1979).

Similar to the civil rights movement, the independent living movement became concerned with both basic rights and benefit rights (DeJong 1979). As detail in the heading "disability movement", disabled people made movements in order to gain political consciousness and to exert a powerful influence on social change (Oliver 1996; 1997). They wished to have opportunities to educate, work, enjoy their lives as other people in the community.

2.3.3.2 Consumerism

Consumerism is another movement that had an impact on the independent living movement. Consumerism began in the late twentieth century (Shakespeare and Watson 2001) and embraced almost all social classes and groups in society, including disadvantaged groups (Peat 1997a). Consumerism is based on a belief that people have the right to make their own decisions about products and services (Peat 1997a). This means that the consumer should be informed about product reliability or service adequacy (DeJong 1979). Disability consumerism developed from a basic need to be informed and enabled to make decisions about issues, products and services related to one's own life (Peat 1997a). Consumerism played an important role in the independent living movement because it proposed that disabled people were the best judges of their own interests and that they should have the stronger voice in selecting services that were offered by disability service providers (DeJong 1979).
Consequently, professional dominance in determining disability policy and rehabilitation was challenged. Consumerism rejects a traditional medical approach, which neglects the involvement of disabled people in the process of decision-making and assumes that disabled people are sick and unable to take control of their personal issues (Peat 1997a).

2.3.3.3 Self-Help Movement

The self-help movement was embraced by several groups such as people with drug addiction and gambling problems, and those who identified themselves as homosexual (DeJong 1979). The concept of self-help was understood as mutual aid provided to and received from others in similar circumstances. The self-help movement aimed to facilitate access to the existing human service systems and to act as an alternative service provider (DeJong 1979). Self-help organisations are often established in order to meet the needs and address problems that are not provided for by other institutions in society (Peat 1997a). They consist of groups of self-motivated people that aim to enable peers in their community to become similarly self-motivated and self-reliant (Armstrong 1993). Members of a self-help organisation typically offer services, material assistance or advocacy to each other (Peat 1997a). Independent living centres are an example of self-help organisations that aim to provide disabled people with opportunities to exercise control over their own lives and the services they use (DeJong 1979). The centres provide knowledge and facilitate awareness for disabled people in order to enable them to take control of their lives and may also provide peer counselling and advocacy services that are not provided by mainline service organisations (DeJong 1979).
2.3.3.4 Demedicalisation

The concept of demedicalisation expresses the concern that too many social problems and life conditions are unnecessarily “medicalised” or controlled by medicine (Anleu 2002). In both Western and Asian countries, health services are primarily organised according to the medical model, where illness and impairment are viewed as conditions of the body in which the structure or function of the body is disturbed or impaired (Lee and McCormick 2002). Physicians are considered to be technically competent experts. Typically, medical care is administered through a chain of authority in which physicians are the principal decision-makers. Patients are expected to assume the sick role, which exempts them from fulfilling their normal social duties (Anleu 2002; French and Swain 2001) and carries the expectation that they will cooperate with health professionals in becoming well (DeJong 1979). Illness is diagnosed, certified, and treated only by trained medical practitioners (Oliver 1990).

The main purpose of medicine is the provision of acute and restorative care through the use of clinical procedures such as surgery and drug therapy (DeJong 1979). In relation to rehabilitation, analysis and intervention focuses on the functional limitations that an individual has, the effect of limitations on activities of daily living, and attempts to prevent, cure, or care for disabled people (Williams 2001).

The demedicalisation movement began when people reacted to the excesses inherent in the provision of health services and argued that certain conditions and life events such as disability, homosexuality and drug addiction should be demedicalised (Anleu 2002). With the rise of demedicalisation movement, the dominance of medical professionals in the scope of human life was challenged (DeJong 1979). This movement represents an extension of the self-help movement in the areas of health
and medical care (DeJong 1979). It encourages individuals to take greater responsibility for their own health and medical care relating to minor health problems and complications arising from chronic health conditions (Oliver, 1990). The independent living movement is closely aligned with the demedicalisation movement. It encourages disabled people to reject the sick role as expected in the medical model. It recognises that the sick role is only appropriate for people with short term conditions from which they can recover and is not appropriate for disabled people where there is no immediate recovery or likelihood of regaining one’s original physical condition (DeJong 1979).

2.3.3.5 Deinstitutionalisation
Since disabled people, whose condition was not likely to improve, needed more specialised or extensive care than families were considered able to provide, they began being institutionalised. Institutional care emphasised controlling and separating from mainstream community life those who were poor, disabled, ill or simply old (Australia’s Welfare 2001). The most prominent culture in institutional settings is the dependency which is created by the passivity of patients inherent within the medical model and the impaired role that requires disabled people to accept their impairments and dependency as permanent (DeJong 1979). In institutions, disabled people are encouraged to follow instructions, timetables and regulations. However, prolonged institutionalisation is known to have harmful effects on disabled people because it does not prepare them for life outside of the institution (Yoshida 1994). Therefore, deinstitutionalisation was developed as a principle that rejects the notion of living in an institutional setting for a lifetime and promotes the use of institutions such as hospitals for short periods of time only (Anleu 2002). It influenced the independent
living movement by encouraging disabled people to take responsibility for their lives and assert their rights to full personhood, which includes living in the community and participating in community life (DeJong 1979).

In summary, apart from the social model of disability, other social movements which included the civil rights movement, consumerism, the self-help movement, demedicalisation, and deinstitutionalisation also influenced the independent living movement in encouraging disabled people to demand their rights, determine the type of services and resources they required and ensure that these occurred outside the medical system, thereby taking responsibility on issues relating to their lives, rejecting the sick role imposed on them by the medical system and seeking to live independent, active lives in the community. However, these concepts originated in western culture. It was a fact that the independent living movement was something which was in one country, grew from that culture’s history and current needs of disabled people in that country. Therefore, it may not apply to countries outside western culture.

2.3.4 Independent Living Worldwide

Historically, the independent living movement resulted from the efforts of disabled people who sought to claim their rights in society. It is a concept being recognised and accepted by disabled people worldwide. This section details how the independent living movement arose and key events propagating the independent living concept.

From the analytical work of Anne Finger about for the prerequisites to the formation of an independent living movement worldwide, four prerequisites were reported (World Institute on Disability [no date]). The first prerequisite was a sense of
commonality among disabled people in institutions. Disabled people wished to avoid being viewed as people who were in need of cure who required provision of benefits and services which address disability in a paternalistic manner. Another important step on the road to independent living was the establishment of organisations addressing specific disabilities. Even though, specific disability organisations located the problem within the disabled individual rather than as part of a broader social structure, these organisations brought disabled people into contact with each other. This resulted in them being able to develop peer relationships and a sense of community. The next important development occurred when disabled people began to form social organisations where disabled people met and interacted. For example, Paralympic Games brought disabled people into contact across national borders. They began to interact with each other, and began to discover commonalities. The next development was self-organisation: disabled people moving beyond social networks to form groups working for social change.

When considering the events that began to create the independent living concept nationwide, two could be considered as having promoted the concept. The first event was the establishment of the first centre for independent living at Berkeley, California in 1972 following with many independent living centres in a short time (Doe 1999). Many disabled people in the USA became united, and then won the amendment of rehabilitation law in 1978. As a result, independent living centres had great opportunities to gain subsidies from the federal government (Nakanishi 2007). Another event to promote independent living was an academic paper written by DeJong (1979). It significantly changed the way of thinking toward disabilities, from
rehabilitation to independent living. With this paper, the philosophy of independent living was accepted as a social movement on an academic basis (Woodill 2006).

This section reviewed precursors to an identifiable independent living movement and what significant events promoted independent living worldwide. In the next section, characteristics of independent living in developed and developing countries are analysed.

2.3.4.1 The Independent Living Movement in Developed Countries

The independent living movement gave dreams and wishes to disabled people. It has grown into service provision systems through the work of disabled people themselves and advocacy activities by independent living centres in the last 30 years in all developed countries, except the Oceania region (Nakanishi 2007). Now, many independent living centres have been established in developed countries, such as the National Council on Independent Living in USA, the Canadian Association of Independent Living Centres in Canada, the Japan Independent Living Centre in Japan, and the European Network on Independent Living in Europe (Nakanishi 2007). They provided services both direct services and advocacy services (O'Day et al. 2004; Takamine 1998). Providing direct services aimed to enable disabled people to leave institutions and to live independently in the community. On the other hand, advocacy helps disabled people receive existing public services to which they are entitled. It also increased awareness of disability and promotes changes in society which benefit all. Normally, services provided by the independent living centres included dispatch of personal assistants, peer counselling, independent living skill training, advocacy activities, providing information, housing and social welfare referral, equipment, and
transport (Hasler 2003; Nakanishi 2007). It was stated that the development of the independent living movement in developed countries occurred in parallel to the recent development of new technology and assistive devices (Takamine 1998). In addition, the availability of social services for disabled people in the community was noticed to be prerequisite for the development of independent living programmes (Takamine 1998).

2.3.4.2 The Independent Living Movement in Developing Countries

As mentioned previously, independent living began in the Western industrialised countries. Through organisations like the Disabled People International (DPI), it has gradually made headway in developing countries. Many European, US and Japanese leaders of the independent living movement have travelled abroad and helped spark the formation of movement in other countries in South Africa and Asia. Even though, social action for equal opportunities led by disabled activists is the biggest strength of independent living, it has tended to be a middle-class movement and often leaves out the poor (Warner 1998). The needs of poor disabled people are misinterpreted to fit the priorities of Western disability activists (Warner 1998). Therefore, the independent living movement in developing countries, where disabled people live with poor, limited resources, and different culture from Western or developed countries, was different. Conditions concerning independent living in developing countries are described below.

It is often stated that the term independent living has not yet been well received by disabled people in developing countries (Nakanishi 2007, Takamine 1998). This was a result of people in this region tending to adhere to a more harmonious existence
rather than confrontation (Takamine 1998). They were more concerned about group conformity imposed by the family, peers, clan and the community they lived in. In societies with a strong sense of community, rooted in extended families, it was suggested that living inter-dependently may be more suitable than living independently as promoted in developed countries (Takamine 1998, Werner 1998). It seemed to be difficult for disabled people in developing countries to exercise full control over their own lives. Living independently required a lot of effort from disabled people themselves and their families. For the parents of disabled children, they tended to feel guilty if they abandoned their disabled children without their protection. They were afraid of criticisms from other people. The parent dispute was the first obstacle that disabled people in this region faced when they tried to leave the family home for independent life. For disabled people, it would be a big step for them to try independent living as they have never been encouraged to be independent for their entire life and lack skills to deal with solitude.

In addition, almost all developing countries tried to get disabled people to be independent through CBR produced by experts, in the same period of the IL movement (Nakanishi 2007). Simple rehabilitation work and assistance in daily life were provided by CBR workers, trained non-disabled people in their communities. Even though, the quality of life for disabled persons might be improved to some extent, through basic physical training, walking training, sign language education, and contact with CBR workers. However, CBR did not necessarily bring independent living for disabled people (Nakanishi 2007). This is because CBR was firstly created as outreach services (Cheausuwantavee 2005; Nakanishi 2007). This resulted in
disabled persons being under the control or management of experts without disabilities (Nakanishi 2007).

Because of poverty and lack of social resources, it was considered to be difficult for disabled people to live independently (Fisher and Jing 2008; Nakanishi 2007). The disability movement in developing countries was mostly based on the concept of self-help, as interdependency was the basis of community living (Takamine 1998; Werner 1998). Disabled people had to help each other in order to survive (Takamine 1998; Werner 1998). Some self-help organisations focused on activities that help members to pursue economic independence such as job training, employment referral, and assistive devices (Takamine 1998). Even though, self-help organisations in developing countries were established under restricted conditions in terms of resource availability and with initiatives of disabled people without influence from abroad sometimes, self-help organisations of disabled people in developing countries shared many characteristics with independent living programmes including self-determination and control by disabled people, self-advocacy and mutual support in order to support the participation of disabled people in community lives (Takamine 1998; Werner 1998).

Apart from establishing self-help organisations, there were three activities used as a way of spreading the independent living philosophy in developing countries. These included promoting a theoretical framework of independent living, advocacy, and showing a role model as an example of independent living (Nakanishi, 2007). Regarding promoting a theoretical framework, there were two independent living seminars held in the Asia region. However, most disabled people who were
enthusiastic after the seminars found it difficult to create a movement in their own country because they were bound with responsibility to family and work until they had no time for creating the independent living movement. Only a few disabled people could make some changes in their countries (Nakanishi 2007). For example, Topong from Thailand who tried to promote the independent living movement in collaboration with 3 organizations of disabled people in different provinces. In developing countries such as Brazil and South Korea, advocacy was a useful activity in spreading the independent living philosophy (Nakanishi 2007). Disabled people engaging in demonstrations was not an example of advocating for things they wanted but it also enabled other people to know about their rights to live in society as others. Concerning showing the role model of independent living, some disabled people in developing countries who received independent living training from independent living centres in developed countries acted as a role model and encouraged other peoples in their countries to live independently (Nakanishi 2007).

In conclusion, independent living seems to be a culturally loaded term. However, self-determination and control of their own lives seems to be a common goal for disabled people in both developed and developing countries. To achieve the same goal process may differ depending on cultural, social, and economic conditions in which disabled people live. Each process should be recognised as it was a unique process of empowerment of disabled people in the unique cultural, social and economic environment.
2.4 The Role of Occupational Therapy in the Independent Living Movement

An understanding of independent living values is crucial to appreciating the far reaching ramifications they hold for the health sciences. In contrast to the medical model, in which the disability itself is an obstacle to independence, the independent living movement view is that the dependence fostered by traditional service models and society at large is often the cause of problems. The solution lies in consumer control, self-help, advocacy, removal of barriers, and peer counselling. While the desired outcomes of the medical model are adaptation and adjustment through professional intervention, the independent living movement strives for self-direction, social and economic productivity, and the human dignity in risk that fosters growth and development.

When independent living is linked to occupational therapy, a question occurs as to whether occupational therapy, a health profession, can work in concert with the independent living movement. From the documented tenets of occupational therapy, it is suggested that occupational therapy is a profession uniquely cited between the medical model and a holistic view of health as something far more than absence of disease (Kennedy 1989). It is affirmed by the American Occupation Therapy Association that occupational therapy can serve a vital role in independent living programs (Bowen et al. 1993). This could be because the philosophy of the independent living movement parallels that of occupational therapy. After all, occupational therapists advocated for the right of the individual to live as independently as possible in the community, and also work to promote environments and attitudes that facilitated that process (Bowen et al. 1993). Townsend (1993) also
reinforced this when she provided her vision of the role of occupational therapists in social justice. She stated that “occupational therapy’s vision is to promote social justice by enabling people to participate as valued members of society despite diverse or limited occupational potential” (Townsend 1993; p 176). However, it was noted that the term “independence” in occupational therapy literature should be recognized in accordance with the independent living paradigm. Rather than performing activities without cueing, supervision or assistance, personal assistant services should be considered and independence should be viewed as the degree of control individuals have over their own lives based on the choice of acceptable options that reduce dependence on others in making decisions and performing daily activities (Kennedy 1989).

The relationship between occupational therapists and consumers, a role of disabled people raised by the independent living movement, was suggested to be in the form of collaboration (Bowen et al. 1993; Passmore et al 2008). Occupational therapists should work based on the philosophy of client or person-centred practice (Passmore et al. 2008). Even though client or person-centred practice was a concept generated from Western culture, it was confirmed that this type of practice fit well in non-Western culture (Ho 2008). According to the client or person-centred practice, when disabled people identify their own goals, occupational therapists should take a proactive role in listening to the voices of disabled people and work with them in order to respond to their needs focusing on adaptation and modification of their strategies and the environment rather than the remediation of an underlying impairment (Bowen et al. 1993; Passmore et al 2008). Additionally, hospital based occupational therapists
should make appropriate referral to community resources in order to enable disabled people to live actively in the community (Bowen et al. 1993).

In summary, because of having an understanding of the dynamic interplay between the individual and the environment, occupational therapists could provide services in independent living settings, and suggest and implement modifications to enhance the individual’s ability to function in a given environment. After all such a collaborative approach and client-centred practice are considered to be appropriate for occupational therapists to use when dealing with consumers.

Conclusion
This chapter has highlighted the potentially conflicting nature of the concepts of disability and particularly the differing views of the disability and medical movements. Earlier in the chapter, the different models of disability were outlined and needed to be considered in the context of Williams’ (2001) view that these apparently distinct and clear models have along history of disagreement and conflict. This makes each individual concept less than clear cut. The current situation seems to be disagreement between the activists disability movements’ view of disability discrimination as being grounded in general discrimination and societal barriers as the creators of disability versus the medical sociologists’ view. In the medical sociologists’ argument, a more pragmatic, medical view of services being required to address issues at the impairment level, as well as at the societal one is offered. Impairment they would argue cannot and should not be ignored, neither is all the blame for disability to be laid the feet of society’s attitude to disabled individuals. In essence, such a political dichotomy could deny any need for physical rehabilitation.
What this actually means for the many countries which have been on the sidelines of this debate and conflict of ideas, is the need for services to identify with their own disabled people and service providers the view of disability which predominates in their culture and whether any of the disability movements or independent living movement's views have any currency in these countries (in this thesis in Thailand). Chapter three will now put these concepts into Thai context and relate that to Thai occupational therapy.
Chapter 3
Independent Living in the Thai Context

This chapter will provide scenery of Thailand relating to disability. It will critique the concept specifically within a Thai and a Thai governmental context. Furthermore, it provides information of healthcare services and occupational therapy in Thailand.

3.1 Independent Living in the Thai Context

The independent living concept has been spread throughout the world including Thailand. In this section, the development of independent living in Thailand is described. Before that, an overview of Thailand, information about disability in Thailand with respect to its definition, the number of disabled people and the prospects of those living with disability are provided in order to enable readers to understand more about disability in the Thai context. In addition, the role of the Thai government in disability from the beginning to the present and its plans relating to disability are discussed.

3.1.1 Country Profile

Thailand covers an area of approximately 514,000 square kilometres (CIA World Factbook n.d.). It is located in the centre of Southeast Asia (see Figure 3.1) and is bordered by Myanmar to the north and west, Laos to the north and east, Cambodia to the east and southeast, and Malaysia to the south. The country is divided into four economically, socially and culturally different distinct regions of North, Central, South, and Northeast. Each of these regions maintains a distinct identity based on
long established customs and traditions as well as dialect and language differences. The capital city is Bangkok located in the central region which is the primary focus of industry, manufacturing, mass communications and government. The Thailand population is 65 million (CIA World Factbook [no date]).

Figure 3.1 Map of Thailand (Modified from Thailand map CIA version)
Thailand is a democratic country, having the King as Head of the State, a constitutional monarchy under the Constitution of the Kingdom of Thailand of B.E. 2540 (A.D.1997), promulgated on 11 October 1997. The Constitution is regarded as the first people’s constitution of the nation. There are three major administrative categories including central, provincial and local administration. The central administration falls under the basic concept of centralisation and consists of 20 ministries. The provincial administration comes under the concept of deconcentration, which means that the central government delegates some of its power and authority to its officers who work in provinces and districts. These officers are from various ministries and departments and carry out their work according to laws and regulations assigned by the central government. Local administration is based upon the concept of decentralisation, which allows local people to participate in local affairs under certain laws and regulations. In general, development policy and planning in Thailand is a combination of top-down and bottom-up approaches (Ministry of Public Health 2005).

3.1.2 Definition of Disabled People

In Thailand, the 1st Economic and Social Development Plan 1981 identified disabled people as a special target group who needed rehabilitation (Bureau of the Empowerment for Persons with Disabilities [no date]). Until the landmark legislation of 1991, the Rehabilitation of Disabled Person Act, a "disabled person" was defined as "a person with physical, intellectual or mental abnormality or impairment classified by type and criteria designated in the ministerial regulation" (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991: pp. 1). In 2003, Thailand revised the definition of disability in line with the
ICF’s definition of disability. The new Thai definition states that a disabled person means “an individual who is limited by function and/or ability to conduct activities in daily living and to participate in society through methods used by persons without disabilities due to visual, hearing, mobility, communication, psychological, emotional, behavioural, intellectual or learning impairment, and has special needs in order to live and participate in society as to others” (Asia-Pacific Development Center on Disability 2005, para.1). Even though, the Rehabilitation of Disabled Persons Act was replaced with the Person with Disabilities’ Quality of Life Promotion Act A.D 2007 (B.E. 2550), this definition of disabled people was retained (Ratchakitcha [no date])

The general term used in Thai for disabled person is “pi garn” (Naemiratch & Manderson 2009). Most Thai dictionaries translate pi garn into English as "maimed", "deformed", and "crippled". Lay understanding of and response to “pi garn” are generally more complex depending on people’s attitudes (Naemiratch & Manderson 2009). However, this term is employed throughout the country to refer to disabled people with all types of disability. It also covers a wide spectrum of severity, ranging from mild deformities to severe cases (Naemiratch & Manderson 2009).

While “pi garn” is meant to refer to disabled people, “pok ka ti” in Thai is used as “usual” or “normal” in English, and “phid pok ka ti” in Thai, although translated as “abnormal” in English, are terms used often particularly in health care services. However, even health professionals in Thailand who have been influenced by Western knowledge do not connect these terms with making negative judgements about people who deviate from valued cultural norms.
3.1.3 Numbers of Disabled People

No national census on disabilities has been conducted in Thailand. The National Statistics office regularly conducts a nationwide survey of the disabled population every five years, which is a part of the Health and Welfare Survey. The latest survey conducted in 2007, found there were 1,871,860 disabled people in Thailand or 2.9% of total population (National Statistical Office 2007). It was estimated that there will be 257,622 severe disabled people in the next 10 years due to the changes of social, economic, and epidemiological transitions from communicable diseases to non-communicable diseases (Sungrugsa et al. 2008).

Since 1994, the office of Empowerment for Persons with Disabilities under the Ministry of Social Development and Human Security has provided a registration service for disabled people. By 31 January 2003, 343,526 disabled people had registered (Asia-Pacific Development Center on Disability 2005). Even though, the number of registered disabled people has dramatically increased to 855,973 as of 30th September 2009, (Office of Empowerment for Persons with Disabilities 2009), there are still many disabled people, particularly in remote areas, that are not registered or may not know they can register (Asia-Pacific Development Center on Disability 2003) and, consequently, have limited access to social services.

Most disabled people live in the North area of Thailand (National Statistical Office 2007) and approximately 70% live in rural areas (Asia-Pacific Development Center on Disability 2003). Most of them have physical impairments (34.78%) (Office of Empowerment for Persons with Disabilities 2007), low or no education (93.4%) (Office of Empowerment for Persons with Disabilities 2007) and most (71.5%) are
not employed (Office of Empowerment for Persons with Disabilities 2007). For those who are employed, 47.5% out of them have their own business whilst 29% are assistants in their family businesses (Office of Empowerment for Persons with Disabilities 2007). Only 19.4% of employed disabled people work in private companies (Office of Empowerment for Persons with Disabilities 2007). The statistics show that most disabled people in Thailand have difficulty in becoming employed. In addition, it implies that most of them consequently have financial problems. This is confirmed by the statistics that show approximately 70% of disabled people have a low monthly income [lower than 3,000 Bahts or 43 Pounds] (Office of Empowerment for Persons with Disabilities 2007).

3.1.4 Living with Disability

Religious and cultural beliefs play a significant role in the lives of people worldwide (Loveland 1999). Disability is viewed inconsistently across cultures (Selway and Ashman 1998). To develop a deeper understanding about disability, it is necessary to consider the roles of religious and cultural beliefs in the lives of disabled people. In Thailand, 95 percent of the total population are Buddhists (CIA World Factbook [no date]). The Buddhist’s concern is to fulfil one’s karma and in a discussion of ‘quality of life’, goals such as being a good person and having peace of mind are promoted. These goals embrace concepts such as correct conduct, correct mentality, living the life one should live, and being the person one should be. Buddhists view good health as the cumulative effect of good karma and view disability, sickness and even death as supernatural punishments for a person’s failure in their correct living or that of their family members and ancestors (Chirawatskul et al. 2008; Miles 1995; Naemiratch & Manderson 2009; Ratanakul 1999). Disabled people and their families normally view
disability as a product of karmic retribution, and consequently view disabled people with pity (Viboolpholprasert et al. 1997). These beliefs, according to Buddhist thought, are unlikely to lead to the achievement of ‘equality of esteem’ for disabled people or motivation to overcome disability and handicap (Miles 1995).

Thailand is a collectivist society where people live closely together with family members including extended family members which is sometimes expanded to include neighbours, covillagers, and servants (Hofstede 2001). Collectivism embraces security, good social relationships, group harmony, interdependence, family integrity, social order, respect for tradition, honouring parents and elders, and politeness. Among other activities, collectivism is achieved through good deeds to assist the sick, the poor, relatives, teachers, and friends (Triandis 1995). In collectivist cultures, people learn that their lives are involved with the lives of others, creating emotional dependency, interest in, and concern for the consequences of decisions on others (Triandis 1995).

In addition, Thailand has a paternalistic view of disability. Most Thai disabled people are traditionally cared for by their families (Oka 1988). According to cultural norms, Thai people believe that helping disabled people will bring good fortune or karma (Naemiratch & Manderson 2009; Viboolpholprasert et al. 1997). Helping less fortunate people such as disabled people, also allows non-disabled people to increase their social reputation. Therefore, families, relatives and even neighbours prefer to provide assistance to disabled people rather than support their independence. The study about informal care for disabled stroke survivors of Ponsoongnern (2007) indicated that their families provided informal care to disabled people in all types of
activity including activities of daily living, household activity, health care activity, and instrumental activity of daily living with average monthly time spent 94 hours. Even though disabled people may gain benefits particularly in health and emotional aspects when being cared by family, it results in disabled people becoming increasingly dependent and, subsequently, impacts upon their self-esteem (Chuenklin 2000; Viboolpholprasert et al. 1997)

With respect to living independently in the community, similarly to other countries in Asia, disabled people in Thailand rarely appear in public or have an opportunity to actively participate in the community (Boonyarattanasootorn et al. 2009; Chirawatsekul et al. 2008). The principle barriers for disabled people in Asia to living independently are physical and attitudinal barriers (Komardjaja 2001). Physical barriers that prevent Thai disabled people from participating in the community include environmental barriers such as architectural and transportation barriers (Kovindha 2000). However, public sector hospitals and department stores currently were reported to be the most convenient places for disabled people to access services (Boonyarattanasootorn et al. 2009). In addition, other people’s attitudes also prevent disabled people from taking up productive roles in the community in employment and education (Boonyarattanasootorn et al. 2009, Oka 1988). In addition generally in Thailand, there is a societal expectation that disabled people will be financially supported by their own families (Oka 1988).

However, Thailand has been becoming a capitalist economy focussing on industrial development as well as materialistic development and competition (Ministry of Public Health 2005). This tends to change the family structure from an extended family to a
nuclear one (Ministry of Public Health 2005). The average family size has gradually dropped from 5.7 persons in 1970 to 3.5 persons in 2002 and is expected to drop further to 3.09 persons in 2020 (Ministry of Public Health 2005). Additionally, the Thai family livelihood has also changed (Ministry of Public Health 2005). Family members now need to work outside the home to financially support the family, resulting in family members having less time to talk and help each other. As disabled people have a tendency to be left alone at home, the changes in the family structure and livelihood are a mechanism that forces disabled people to be more independent and self-reliant.

3.1.5 The Thai Government and Its Role in Disability

The Thai government has long expressed a concern to provide help and support for disabled people. Organised social work for disabled people could be divided into two periods by the instigation of the Rehabilitation of Disabled People Act. The first period was the institutional care period while the second period followed the Rehabilitation of Disabled People Act when a more holistic approach to the needs of disabled people was acknowledged. It is, however, important to note that these two periods are not watertight periods, as there are some overlaps in the developments. Table 3.1 shows a timeline concerning independent living in Thailand.
Table 3.1 A timeline concerning independent living in Thailand

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1941</td>
<td>Residential home for disabled people established near Bangkok</td>
</tr>
<tr>
<td>1968</td>
<td>First vocational rehabilitation centre for disabled people and the Pak Kred sheltered workshop set up</td>
</tr>
<tr>
<td>1979</td>
<td>Rehabilitation of Disabled Persons Act began to be drafted</td>
</tr>
<tr>
<td>1983</td>
<td>Thai government committed to the “UN Decade of Disabled Persons”</td>
</tr>
<tr>
<td>1991</td>
<td>Rehabilitation of Disabled Persons Act</td>
</tr>
<tr>
<td>1993</td>
<td>Thailand became a signatory of the Proclamation on the Full Participation and Equality of Persons with Disabilities in the Pacific Region</td>
</tr>
<tr>
<td>1997</td>
<td>Thai Constitution</td>
</tr>
<tr>
<td>1997-2001</td>
<td>National Plan of Rehabilitation of Disabled People</td>
</tr>
<tr>
<td>1998</td>
<td>Declaration on Rights for People with Disabilities in Thailand</td>
</tr>
<tr>
<td>2002-2006</td>
<td>The 2nd National Plan of Quality of Life Development</td>
</tr>
<tr>
<td>2007</td>
<td>Signed the Convention on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>2007</td>
<td>Amendment of the Thai Constitution A.D. 1997</td>
</tr>
<tr>
<td>2007</td>
<td>Person with Disabilities’ Quality of Life Promotion Act</td>
</tr>
<tr>
<td>2007-2011</td>
<td>The 3rd National Plan of Quality of Life Development</td>
</tr>
<tr>
<td>2008</td>
<td>The Persons with Disabilities Education Act</td>
</tr>
</tbody>
</table>

The country’s welfare services for disabled people started in 1941, when a residential home for disabled people was established in Samut Prakan province, near Bangkok. In the early days, people with severe disabilities who were discharged from hospitals would stay at the residential home. They were offered services that met their basic
needs including food, clothing, medical care and accommodation (Economic and Social Commission for Asia and the Pacific 1999a).

In 1968, under the supervision of ILO, the first vocational rehabilitation centre for disabled people was set up in Samut Prakarn which provided vocational training in various fields. Then, the Pak Kred sheltered workshop was also set up. Thus, disabled people in Thailand were provided for in their four major areas of need including medical, educational, occupational and social rehabilitation. In addition, there were also various government and nongovernment task forces set up to provide these services (Economic and Social Commission for Asia and the Pacific 1999a).

In 1979, the Thai government began drafting the Rehabilitation of Disabled Persons Act to protect the rights of disabled people and also to provide standards for workers (Economic and Social Commission for Asia and the Pacific 1999a). In 1983, as a member of the United Nations Economic and Social Commission for Asia and the Pacific (UN-ESCAP), the Thai government committed to the “UN Decade of Disabled Persons” from 1983-1992 (Independent Living Research Utilization 1999). Consequently, Thailand sought to raise awareness and disseminate knowledge about the needs of disabled people throughout the community.

After much effort over twelve years, the Rehabilitation of Disabled Persons Act was announced in 1991. It was the first Thai law specifically dealing with disabled people and recognised them as important human resources who should be provided with equal opportunities to work and participate in social activities (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons...
Act 1991). In an effort to address existing issues and remove economic and social barriers, this Act states that disabled people should be entitled to receive assistance, development and rehabilitation in five main areas including medical attention, education, vocational training, participation and equality, and governmental organisations and lawsuit services (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991).

Apart from the national level, Thailand also provided support for disabled people at the regional and international levels. In 1993, Thailand signed the Proclamation on the Full Participation and Equality of Persons with Disabilities in the Asia-Pacific Region by the Economic and Social Commission for Asia and the Pacific (ESCAP). Thailand played an active role in the regional programs especially in conjunction with UN-ESCAP. Thailand was one of the three countries selected by ESCAP to work on a pilot project of the Promotion of a Non-Handicapping Environment for Disabled Persons and the Elderly. In 1998, Thailand signed the Declaration on the Rights of Thai Persons with Disabilities. This Declaration is a pledge made by the people of Thailand to the disabled person and is today used as a reference in the provision of services for disabled people. Recently, the Thai government also signed the Convention on the Rights of Persons with Disabilities, an international human rights instrument of UN intended to protect the rights and dignity of disabled people (United Nations 2006). It seemed to be another step for improving quality of life of disabled people in Thailand when the Thai government implement the Convention into its legislation.
Currently, there are three pieces of legislation concerning the rights of disabled people being enforced. The first one is the Thai constitution, adopted in 1997, aiming to enhance citizen participation, transparency, empower local communities, and improve the public sector government (Asia-Pacific Development Center on Disability 2005).

As a result of implementation of the Convention, anti-discrimination provisions based on physical or health conditions and guarantees accessibility to social welfare and services for disabled people were added into the Thai constitution in 2007 (United Nations 2009).

The second important piece of legislation is the Person with Disabilities' Quality of Life Promotion Act A.D 2007 (B.E. 2550) (United Nations 2009). It was created in order to replace the Rehabilitation of Disabled person Act A.D. 1991 (B.E. 2534). It is a comprehensive rights-based law for disabled people and contains an anti-discrimination component. It includes sections dealing with medical rehabilitation, social rehabilitation, education and vocational rehabilitation. As stated in this act, the Thai government provides disabilities allowance of 500 Baht (10 Pounds) per month to registered disabled people. In addition to the disabilities allowance, those persons who are over 60 years old are also entitled to an old age allowance of 500 Baht per month (Ministry of Foreign Affair 2010). However, these allowances were deemed to be less than the amount of financial support that disabled people wanted (average 3,549.45 Baht or 70 Pounds) (Sungrugsa et al. 2008). Apart from financial support from the government, disabled people are also supported to work (Ministry of Foreign Affair 2010). Both public and private organisations are mandated to hire disabled people to any position from a ratio of 1 disabled person to every 200 regular employees to 1 disabled person to every 100 regular employees. These organisations
are also requested to provide an annual contribution to the Fund at an amount equal to the minimum wage a disabled worker would have been paid (Ministry of Foreign Affair 2010). In addition, disabled people can obtain loans for the Fund in order to assist in self-employment with a 5 year repayment term and no interest rate (Ministry of Foreign Affair 2010).

Finally, the Thai government recently developed the Persons with Disabilities Education Act A.D. 2008 (B.E. 2551) to attempt to deal with illiteracy amongst the disabled and develop continuous education for disabled people. This act aimed to establish access to educational services and other resources at all levels to improve the Thai education system. Disabled people in Thailand are entitled to receive education at all levels from compulsory education and up to the university level free of charge. They can choose to study in both special programmes and alongside other students (Ministry of Foreign Affair 2010). It was expected that it could support disabled people to have quality of life and promote independent living through empowerment.

In summary, the Thai government’s role in disability has been gradually changing over six decades. Even though it began by providing welfare services for disabled people, it is currently focused on enhancing the potential of disabled people in order to enable them to live independently and be active members of society.

3.1.5.1 The National Plan of Quality of Life Development of Thailand

Apart from legislation mentioned above, Thailand also has particular plans and strategies on disability that have been influenced by the plans and missions related to disability at international and national levels. The first plan was announced in 1997
named the National Plan of Rehabilitation of Disabled People A.D.1997-2001 aiming to rehabilitate disabled people medically, educationally, vocationally, and socially in order to enable them to have sufficient capabilities to live in the community (Office of Empowerment for Persons with Disabilities 2007). Then, the second National Plan of Quality of Life Development 2002-2006 was developed following a review to supersede the National Plan of Rehabilitation of Disabled People. Using the lessons learned from the previous plan, this national plan was designed to fit within the Thai contexts by integrating all aspects of quality of life development for disabled people. It focused on participation from all in order to promote rights and equality for disabled people (Office of the National Economic and Social Development Board 2006a). Currently, Thailand is using the Third National Plan of Quality of Life Development 2007-2011 (Office of Empowerment for Persons with Disabilities 2007). Through an integrated approach and guidelines for disability and development practice for all authorities concerned in the plan, disabled people would be able to protect their rights, have good quality of life in accordance with their optimal potential, and fully and equally participate in social activities under a barrier-free environment (Office of Empowerment for Persons with Disabilities 2007). The National Office for the Empowerment of Persons with Disabilities (NEP) under the Ministry of Social Development and Human Security is the main body responsible for policy planning, implementing projects and evaluating outcome regarding the development and empowerment of disabled people (Ministry of Foreign Affair 2010). It also works in coordination with other three ministries including The Ministry of Public Health, The Ministry of Education, and the Ministry of Labour (International Labour Organisation 2009). Even though, the Thai government had particular plans for developing the quality of life of disabled people, it has been noted that the
government did not give high priority to the development of life quality for disabled people (Boonyarattanasoontorn et al. 2009). Besides, not all government ministries had clear actions for disabled people (Boonyarattanasoontorn et al. 2009).

As this study was conducted during the transition period of the Second and the Third National Plan of Quality of Life Development, both plans are reviewed in this section. As disabled people in Thailand are confronted with many limitations in their lives, the Thai government developed these two plans by integrating medical, social, and rights based approach together in an attempt to improve the quality of life of disabled people. Eight issues were highlighted as important mechanism including 'promoting positive attitudes towards disability', 'rights', 'potential development', 'accessibility', 'strengthening of organisations related to disability', 'participation from all', 'research and development', and 'integrative management'.

- **Promoting Positive Attitudes towards Disability**

To increase the quality of life of disabled people, promoting positive attitudes towards disability was valued as an important issue that needed to be undertaken. This issue was clearly stated in the second National Plan of Quality of Life Development and also continued to the third volume. To promote positive attitudes towards disabled people, five methods that included 'education', 'media', 'activity', 'religion', and 'participation' were used. Firstly, the government tried to instil knowledge about disability at all levels of the educational curriculum. Secondly, the government provided support for the production of media products relating to disability and encouraged all types of mass communication furthering education about disability. Thirdly, the government provided support for activities that aimed to propagate
disabled peoples' capabilities particularly in the area of education, sport and vocation. Then, the government encouraged religious organisations to interpret and analyse disability in a creative way. Lastly, disabled people particular women, and their family were encouraged to participate in various types of social activity in all sectors and parts of country

• Rights
Rights were considered an important issue when quality of life development for disabled people was promoted. Two strategies were proposed in the second National Plan of Quality of Life Development including ‘building an understanding about rights’, and ‘revising and implementing legal measures’. To build an understanding about rights, disabled people were to be provided with information, their peers were to be encouraged as role models, and advocacy organisations were proposed. Pertaining to revising and implementing legal measures, organisations relating to disability would be used to monitor laws and regulations relating to disability in order that they are effective. Laws and regulations preventing disabled people from having equality of rights were cancelled. Thirdly, the government developed legal measures to protect disabled people being taken advantage of. Lastly, the government established an Act related to disability rights. These methods indicated the Thai government’s enthusiasm in improving the equality of rights of disabled people.

• Potential Development
Potential development of disabled people is always a concern for the Thai government. This issue was put in both the second and third National Plan of Quality of life Development. In the second National plan, the government proposed to
develop the potential of disabled people via five aspects including ‘health’, ‘education’, ‘sport and recreation’, ‘vocation’, and ‘welfare’. In the third National Plan, these services were expected to be built upon and to become more effective.

In the area of health, providing initial health services for disabled people and their families was highlighted as an important strategy for enabling disabled people to have physical, mental, and spiritual well-being. Efficiency of and access to health service provision would be increased. Family and disability organisations were encouraged to monitor and assess health services provided to disabled people. Assistive devices and equipment was provided free of charge. Alternatively, they would receive financial support in order to buy assistive devices and equipments themselves. Furthermore, disabled people and their families also were encouraged to collaborate in the development and propagation of knowledge about equipment and assistive devices using appropriate technology or local materials.

Pertaining to education, the government intended to provide education and advice for all types of disability in order to eliminate the illiterate and develop continuous education for disabled people. Curricula and the learning-teaching process were revised. Financial support would be provided to private schools to enable them to provide education for disabled people. In addition, educational networks and referral systems between all levels of education and types of school, and between educational and vocational organisations were developed. Lastly, establishing an educational fund for disabled people and developing educational staff were proposed.
In the aspect of sport and recreation, disabled people were expected to participate more in sports and recreation. Therefore, providing places, supporting all levels of sport competition, and promoting recreation and travelling activities for disabled people were proposed to use as strategies in this aspect.

With respect to the vocational aspect, the Thai government wished to develop work potential and increase work opportunities for disabled people by using two mechanisms including ‘vocational training’ and ‘employment’. In vocational training, developing vocational preference and work readiness assessment tools, providing an opportunity for disabled people to receive vocational training, improving skills and the qualification of vocational trainers, and the curriculum and the teaching-learning process in vocational training were suggested. In employment, a job seeking system would be developed to enhance work opportunities for disabled people. The necessary accessibility, equipment, media and technology would be provided to disabled people. In addition, the government would offer benefits to workplaces employing disabled people, support workplaces in environmental adaptation and provide accommodation near workplaces. The government would provide knowledge about jobs, marketing, and management as well as skill and product development for disabled people who wished to have their own businesses. Additionally, a protection system would be developed in order to ensure that disabled people received income and welfare and that their safety was ensured. The government would also produce a monitoring and penalty system for workplaces that refused to employ disabled people.

In the welfare aspect, the Thai government wished to improve the social welfare system to guarantee the quality of life development of disabled people. Therefore,
several strategies were proposed. Firstly, the Thai government would encourage local administration to take part in providing social welfare to improve social welfare system. Secondly, financial support would be provided to people with severe disabilities and families. Next, a network for recruiting funds from government, non-government, and the community would be developed in order to ensure that all disabled people and their families could access social welfare. In addition, the Fund for Rehabilitation of Disabled Persons would be used as a mechanism for rehabilitation and provide social welfare for disabled people and their families. Volunteer groups and disability organisations would be established to monitor and support social protection. Furthermore, support would be given to non-government organisations providing shelter services for children or disabled people. An advisory and referral system would be developed. Residential homes would be renovated and improved to assist disabled people. Lastly, registration would be promoted in order to enable all disabled people to register and therefore obtain applicable benefits.

- **Accessibility**

Accessibility was also made a key factor in enabling disabled people to have a quality of life. In the national plans, accessibility did not only encompass the physical environment, but also included pertained to relevant information, communication, service, and technology. The second National Plan aimed to ensure that disabled people could access information and the services they wanted via three strategies including ‘having accessibility for all types of disability’, ‘providing services to enable disabled people to access’, and ‘promoting appropriate accessibility management’.
To have accessibility for all types of disability, the Thai government stipulated accessibility in buildings and transportation for all types of disabled people. Regulations and benefits would be disseminated to facilitate modification of public buildings. In addition, an accessibility supporting system would be provided to enable disabled people and their families to access social services. Training and development would be provided to people who were involved with construction, design and transportation in order to enable them to produce accessible products to meet the needs of disabled people. Furthermore, accessibility and information technology centres for disabled people would be developed.

To enable disabled people to access information, communication, service, technology, and the environment, the Thai government would provide the necessary equipment and technology. Telecommunication and information services would become accessible. Public service providers would be trained to enable them to communicate with people with different types of disability. Government and private organisations would be encouraged to increase the number of people involved with production and dissemination of information technology. In addition, financial support for disabled people would be provided to ensure they could access information, communication, service, technology, and the environment.

To promote accessibility management, a database system would be developed to include all disabled people in the country. Filing, collecting and analysing the data system would also be revised to ensure it was up-to-date at all times. In addition, a network of national and international government, non-government, and disability organisations would be included on an integrative disability database. Lastly, legal
measures for promoting and protecting disability rights regarding access information, communication, service, technology, and the environment would be developed.

Whilst the second National Plan guaranteed accessibility for all types of disability, the third National Plan of Quality of Life Development progressed to a barrier-free society for all. The Thai government would establish and implement a national plan for an accessible environment and information for all. In addition, laws and regulations related to building, transportation, telecommunications, information and communication technology, and assistive technology would be developed or revised. Universal designed curriculum would be promoted. Educational providers also would be encouraged and supported to use the universal design curriculum. Universal design centres would be developed and expanded for teaching and providing service to the community. Lastly, monitoring and assessment mechanisms would be instigated to ensure these new processes were being carried out.

**Strengthening Organisations Related to Disability**

Strengthening organisations related to disability was realised as a mechanism that could enhance the quality of life of disabled people. In the Thai national plans, three guidelines were proposed to strengthen these organisations. Firstly, the establishment of disability organisations would be promoted, including development of the administration in the aspects of finance, knowledge, and human development. Secondly, disability organisations would be encouraged to provide consultancy or take part in committees at the local and national levels to voice opinions leading to decisions for disability administration. Lastly, training would be provided to people in these organisations to ensure sustainable development.
• Participation from All.

Participation for all was raised as an important issue in quality of life for disabled people. In order to promote participation from disabled people and their families, four guidelines were proposed. Firstly, disabled people and their families would be encouraged and supported to formulate policies, plans, and legislation affecting quality of life development. Secondly, communication and information about formulating policies, plans, legislation or services affecting quality of life development should be developed. Thirdly, government and non-government organisations, and people in the community would be encouraged to realise the importance and benefits of participation in quality of life development for disabled people. Lastly, social activity would be improved to enable disabled people and their families to participate in the community without social and physical barriers. Not only disabled people and their families, the Thai government wished to promote participation from organisations related to disability via collaboration among organisations.

• Research and Development

In the national plans, research and development became a strategy for enhancing quality of life for disabled people. Firstly, the Thai government intended to provide financial support for new research and development. Then, the findings would be distributed to the public for practice. A monitoring and assessment system for quality of life development would be developed. Disabled people, their families, disability organisations, and the community also would be encouraged to participate in the monitoring and assessment system.
• **Integrative Management**

The Thai government realised that integrative management was another important issue for quality of life development for disabled people. Integrative management was proposed to be undertaken via 'administration' and 'human development'. Regarding to administration, the Thai government set up a central operating and coordinating committee to take responsibility for quality of life development. In addition, strategy plans would be developed and coordinated between government and non-government organisations. Furthermore, organisations related to disability would be supported to enable these organisations to follow the government policies and plans. Funding was also to be made available to give continuous support to all disability services. In the aspect of human development, the Thai government would promote and support the development of all involved personnel in an effective and systematic manner. The number of people involved with disabled people was also expected to increase.

In summary, this section reviewed the two national plans with eight important mechanisms that the Thai government used to improve the quality of life of disabled people. These national plans indicated that the Thai government had a holistic view of disability issue. However, it was suggested that the Thai government should recognise and give priority to the development of the quality of life of disabled people. From the national plans reviewed above, it is necessary to investigate whether the plans are recognised by professionals working within the area of disability such as occupational therapists and to what extent they conduct their work in accordance with the plans.
3.1.6 The Development and Impact of Independent Living in Thailand

Disabled people in Thailand began to play a more assertive role in Thai society when, the Council of Disabled People of Thailand or the Disabled People International-Thailand (DPI-Thailand), a national group of disabled people, was formed in 1983 (Independent Living Research Utilization 1999). After DPI-Thailand was founded, disability issues were raised throughout the country. Following the formation of DPI-Thailand, other associations were also founded, which frequently focused on the needs of people with a particular type of impairment.

In 1988, the independent living concept was introduced to Thailand by Japan. Leaders within the disability sector, i.e. people at the head of disability organisations, had an opportunity to learn about independent living by visiting Japan. From 1988 to 1995, DPI-Thailand’s representatives were invited to attend independent living study programs in several countries including Houston and St. Louis in the USA, Stockholm in Sweden, Christchurch and Auckland in New Zealand, and Winnipeg in Canada (Independent Living Research Utilization 1999; Nakanishi 1998). Consequently, there were many leaders of Thai disabled people who had knowledge about independent living and were ready to make changes for other disabled people in Thailand. They had experience in explicit advocacy roles such as working with the Thai government to establish the Rehabilitation of Disabled Persons Act.

Eleven years after the adoption of the independent living concept in Thailand, the first formal demonstration was organised in 1999 to raise public awareness of access issues, as well as encouraging government and public support for access improvements. Even though there was no report that any disabled people in Thailand
were injured or had died due to accidents when they tried to access public places as had happened in Korea (Nakanishi 2008), their difficulty accessing public places led disabled people in Thailand to conduct the demonstration. The Association of the Physically Handicapped of Thailand and DPI-Thailand organised a demonstration involving 450 people with all types of disabilities (Finger 1999). They demanded that the Bangkok Metropolitan Administration, the body responsible for introducing the Bangkok Sky Train system, construct facilities that provided full access to disabled people. Their demands included the addition of lifts at all stations, open captioning in all stations and in trains for people with hearing impairment, and tactile guiding blocks on the platforms for people with visual impairment. They also demanded training for Sky Train employees in ways to provide assistance to people with different kinds of disabilities. They used this demonstration to influence the government to implement reforms that were consistent with the Rehabilitation of Disabled Persons Act regarding accessibility to public services. As a result of this demonstration and their advocacy efforts, the Bangkok Metropolitan Administration agreed to all of their demands (Finger 1999). Since this was a government project, the Thai government was made aware of the power of disabled people and that they were required to adhere to the Act. In addition, the needs of disabled people have been considered in the planning of the four mass transit commuter rail lines serving metropolitan Bangkok (Access Exchange International 2003). A combination of elevators and ramps will serve 62 elevated and underground stations and other access features will also be provided. To ensure the rights of disabled people in the future, the government then appointed Mr. Narong Patibatsarakich representing DPI-Thailand as a Senator.
In 2002, the Asia-Pacific Development Centre on Disability (APCD) was established in Bangkok, Thailand under cooperation between the Japanese International Cooperation Agency (JICA) and the Thai government (Nakanishi 2008). The first project of APCD was the promotion of independent living in Asia. The project organised programmes lasted five years for peer-counselling and management of independent living centre (Nakanishi 2008). At the first three years, the project focused to the establishment of independent living centres in Thailand (Nakanishi 2008). Therefore, the first training programme on independent living for disabled people began in Thailand in 2002 (Redemptorist Vocational Training School 2002). It was operated by using the collaborative support model that the independent living centres in Japan had instigated (Nakanishi 2008). This pilot project was conducted in three provinces: Nakhonpathom, Nonthaburi, and Chonburi (Redemptorist Vocational Training School 2002; Sungrugsa et al. 2008). The project aimed to encourage self-determination and enable disabled people to live independently in their communities (Redemptorist Vocational Training School 2002; Sungrugsa et al. 2008). The activities of this independent living project included information dissemination about the project, peer group, personal assistance training, visiting and preparing selected disabled people for training in independent living such as financial management, access to organisations for their rights and benefits, community access and participation, and vocational training (Sungrugsa et al 2008). After the project finished, it was perceived that the operation of an independent living project in Thailand was feasible, but it should be performed in the context of strengthened communities through the support from researchers’ networks/leaders and change agents in order to achieve successful and permanent implementation (Sungrugsa et al 2008). The outcomes of the project were used to further develop similar projects in
other provinces (Redemptorist Vocational Training School 2002). The success of the pilot project in enabling disabled people to be independent then influenced the government policies (Nakanishi 2008). With the collaboration more than 10 local government units at village level in Nakhonpathom province, two independent living centres were officially established in the province in order to organise peer support meetings. The centres utilise the meetings as the site to disseminate the rights of disabled people and the philosophy of independent living. The centres’ activity is highly appreciated by the Thai government. Consequently, the centres receive financial support from the Thai government (Nakanishi 2008).

Additionally, the outcome of the first three years of the independent living project in Thailand was used to expand its reach to other Asian countries such as Pakistan, the Philippines and Malaysia (Nakanishi 2008). Disabled people from these countries lived together at APCD in order to exchange information on their movements, foster the sense of unity, and receive independent living training (Nakanishi 2008). All lectures in the training were given by resource persons from Japan. However, disabled people from these countries felt that it seemed to be impossible for disabled people in their country to achieve independent living because of the massive differences between their countries and Japan (Nakanishi 2008). To build their understanding of the independent living movement and prove such a movement could be created in other Asian countries, some Thai disabled people from the first three years of independent living project and the president of the Centre of Independent Living in Seoul, Korea joined to some programmes as assistant resource personnel. This was possible because Thailand and Korea’s economic and welfare conditions were much similar to other Asian countries (Nakanishi 2008). Thus the ideas of the independent
living movement were now being promulgated across Asia from the newly developed movement in Thailand. This then resulted in disabled people from Pakistan, Philippines and Malaysia being motivated to establish independent living centres in their own countries (Nakanishi 2008).

In summary, Thailand has adopted the independent living concept for more than two decades however it remains limited for disabled people in some provinces. It focuses on encouraging self-determination and enabling disabled people to live independently in their communities. Even though, not all disabled people in Thailand have achieved independent living, the attempted implementation of independent living in Thailand could inspire disabled people from other countries in Asia to establish independent living centres in their own countries.

### 3.2 Healthcare Service and Occupational Therapy in Thailand

Health services in Thailand are classified into four levels according to the level of care including primary health care level, primary, secondary, and tertiary care level (Ministry of Public Health 2005). The primary health care services include those organized by the community in providing services related to health promotion, disease prevention, curative care and rehabilitative care. The medical and health technologies applied at this level are generally not so high, in response to community’s needs and culture. Service providers are the people themselves, village health volunteers or other non-governmental volunteers. At the primary care level, service provisions are provided by health personnel and general practitioners. However, there is no holistic care at this level. At the secondary care level, medical and health care are managed by medical and health personnel with intermediate levels of specialization. Hospitals at
this level vary depending on their size (10 to 500 inpatient beds). These include community, provincial, regional and private hospital. Pertaining to tertiary care, medical and health services at this level are provided by medical specialists and health professionals. Tertiary care facilities include provincial, regional, university and large private hospitals. Currently, registered disabled people in Thailand entitle to receive free healthcare services from public hospitals. The study of Wanaratwichit and et al. (2008) indicated that more than half of disabled people in the study could access to all health care services. However, it was a study conducted in only the Northern part of Thailand with a sample of 406 disabled people. It could not be extrapolated to the general Thai disabled population.

In Thailand, rehabilitation is considered to be an important service in enabling disabled people to reach and maintain optimal functional recovery in physical, intellectual, psychological and/or social domains (Wanaratwichit et al. 2008). However, rehabilitation services by an interdisciplinary team are provided mainly at tertiary public sector hospital (Kuptniratsaikul et al. 2009). Not all patients with significant disabilities have an opportunity to receive early and continuing rehabilitation services, either as inpatients or outpatients (Kuptniratsaikul et al. 2009; Wanaratwichit et al. 2008). This is because there is a limitation in the number of various rehabilitation professionals (Kuptniratsaikul et al. 2009). To increase an opportunity for disabled people to receive rehabilitation services, there are several CBR projects conducted in Thailand in order to improve quality of all aspects of life of disabled people. However, it is reported that the evolution of the concept of CBR in Thailand is an ongoing process due to a lack of community provision and a lack of financial support (Cheausuwantawee 2005)
Regarding the limitation of the number of various rehabilitation professionals mentioned above, occupational therapy is one of rehabilitation professionals which is limited in number (Passmore et al. 2008). For example in 2007 there were only 591 occupational therapists registered with the Medical Registration Division, Health Service Support, Ministry of Public Health (2009). This seems a very small number of occupational therapists when compared with the numbers of disabled people in Thailand, 1,871,860 disabled people (National Statistical Office 2007). However, the total number of graduate occupational therapists is actually higher than the number of occupational therapists registered in Thailand. The lack of recognition of occupational therapy in Thailand, results in some graduate occupational therapists changing their fields of interest whilst a few graduate occupational therapists move abroad and work in other countries.

Mostly, occupational therapists in Thailand provide their services in the area of physical disability and paediatrics. Some occupational therapists deal with people with mental health problem whilst a few occupational therapists are involved with elderly people. The distribution of occupational therapists is not even. Not all hospitals have occupational therapy services. Occupational therapists normally work in large hospitals attached to universities, in regional areas, specialised hospitals, and some provincial hospitals whilst few occupational therapists provide services in community hospitals. The hospitals with occupational therapists have approximately 1 to 4 occupational therapists depending on the size of the hospital. Consequently, occupational therapists normally spend most of their working hours providing services to clients in institutional settings. Although, outreach services for disabled people and their families in order to maintain and enhance the functional abilities of
disabled people is important (Chatcheydang 2005; Chinchai et al. 2003; Chinchai and Wittayanin 2008; Obe-om et al. 2006), it is difficult for occupational therapists in Thailand to provide such services due to their heavy work load in the institutional setting. This results in disabled people and their families not receiving the occupational therapy service they need.

Apart from the low number of occupational therapists in Thailand, it is questionable as to whether Thai occupational therapists would be able to provide services to disabled people who need to achieve independent living. This is because they normally work in the institutional setting with others who have an attitude to disability which is based on the medical model of disability (Pongsaksri 2004). According to the medical model, the power of decision-making is controlled by the health professionals. On the other hand, the independent living concept encourages disabled people to take control over decisions in any issues relating to their lives. Whilst the notion of independent living has been spreading within Thailand since 1988, it has never been taught in the Thai occupational therapy curriculums since 1980 (Department of Occupational Therapy 1980, 1999, 2005). This raises a concern as to whether Thai occupational therapists have a sufficient understanding of the independent living as a concept for disabled people to enable it to thrive within Thailand.

3.3 Research on Disability and Independent Living

Independent living in the community for disabled people is an issue that is discussed extensively in the literature and studied from a range of perspectives. According to the philosophy of the independent living movement, disabled people should be able to
take control of their own lives, have options and choices, be able to participate actively in the community and have the same rights as able bodied people. The following section reviews recent studies, which highlights some of the issues encountered by disabled people in achieving independent living.

From the literature, a number of possible factors influencing people to live independently in the community are investigated. These include personal factors, family, peer support, attitudes of people in the community, mobility ability, and financial resources.

A number of studies have shown that a range of personal factors impact on disabled people living independently in the community. The impact of personal resources on community integration has been highlighted in three studies (Grahn et al. 2001; Hendey and Pascall 1998; Wehmeyer and Schwartz 1998). According to Wehmeyer and Schwartz (1998), self-determination of disabled people was an important factor in achieving quality of life. Grahn et al (2001) found that motivation for change towards an active and independent life was dependent on an internal locus of control and a level of coping ability. In addition, motivation for change was affected by the individuals' ability to perceive and express body awareness, accept their own selves and needs, perform things based on their abilities and take care of themselves. A third study, by Hendey and Pascall (1998), also emphasised the impact of fear and perceptions of safety. They reported that people with severe physical disabilities who lived in the East Midlands, in the UK, experienced difficulties leaving the parental home because of their own fears about safety. Their social lives were restricted as a result of a fear of violence and a fear of difficulty in accessing public transport.
However, Hendey and Pascall did not provide information about the living situations of their participants. Whilst some of these fears may have been real, heightened sensitivity to the possibilities of being unsafe or experiencing difficulties restricted these people’s willingness to go out into the community. Whilst these three studies highlight the importance of personal resources in enabling disabled people in Western culture to live independently, disabled people in Eastern cultures like Thailand also perceive personal resources to have a principle role in enabling them to develop themselves and live independently in the community (Panyamee 2005).

Family has also been identified as an important factor for disabled people in achieving independent living. They have been reported as a barrier for students with disabilities finishing school and seeking to live on their own in the community (Hendey and Pascall 1998). Parental anxiety about safety has resulted in young disabled people being overprotected and having limited opportunities to fulfil their lives in the community (Murphy et al. 2000). Rather than limiting the autonomy of disabled people, Householder and Jansen (1999) proposed that parents and family could take a supportive role in planning for the future. For instance, in a study by Morningstar et al. (1995), students with disabilities reported that their families had an influence on the creation of their vision for the future and were involved in the process of planning transitions and facilitating self-determination. These studies suggest that family has an important influence on young disabled people who want to live on their own in the community. Similar to studies conducted in Western culture, family was found to have an influence on disabled people’s lives in the Eastern world. In Panyamee’s (2005) study about exploring the perspective of 13 Thai disabled people on independent living, family were reported to have both a positive and negative impact.
on independent living for adults with acquired physical impairments who had a strong relationship with their families.

Personal assistance is a significant factor in enabling disabled people to attain independent living. Personal assistance is highlighted to be the one of preconditions for equal participation (United Nations 1993). According to the notion of independent living, disabled people are encouraged to be self-directed, active users of services who recruit, select, train, manage, and direct their own personal assistant (Batavia, 1998). It is also proposed by the independent living literature that personal assistant could relieves the feelings of being a burden on their families (Lawrence, 1989; Nosek, 1993). In Western society, the importance of personal assistance in enhancing disabled peoples' opportunities to participate in everyday life at home, at work, in school and during leisure time has long been documented (Barnes 2007; Kennedy 1997; Litvak 1998; Zarb 2003). In Eastern world where there is strongly belief that disabled people are frail individuals in need of care and their family members should be the ones who serve as caregiver, it is also evident that personal assistant could enable disabled people to feel sense of control and reduce their dependence on their families (Wang 2007; Yamaki and Yamazaki 2004).

Peer support has also been identified as a resource for disabled people wishing to live independently in the community. Hibbard et al. (2002) used a questionnaire and in-depth interview to evaluate the impact of a peer support program for people with traumatic brain injury and their family members. They found that peer support was reported to have a positive impact on these people in increasing their knowledge, enhancing their overall quality of life, improving their general outlook, and enhancing
their ability to cope with depression (Hibbard et al. 2002). In addition, peer support was also reported as a community resource that provided social support for families and friends of disabled people as well as other people in the community (Hibbard et al. 2002). However, retrospectively Hibbard et al.'s study might not be able to reflect the real efficiency of a peer support program due to poor reports about events prior to the program intervention. In Eastern culture, peer support was also highlighted as an important resource in the community in enabling disabled people in Thailand to better adapt activities to meet their needs, expand their horizons, and feel that they had the same rights as others (Panyamee 2005).

Attitudes of people in the community towards disabled people seems to depend on the perceived cause of disability, perceived characteristics and activities of disabled people by the community and the perceived role of society (Monk and Wee 2008). Attitudes of people in the community towards disabled people have been examined in many studies. However, their findings varied. Some studies have reported the negative attitudes of people in the community (Macmillan and Soderberg 2002; Stephens and Yoshida 1999; Tighe 2001). Attitudinal barriers have been found to impact on disabled people in several areas of life. For example, a qualitative aspect in David and Jansen’s (1999) study found that, as a direct result of disabilities, lecturers treated students with disabilities differently to the other students. As mentioned previously, people's negative attitudes also hindered disabled people from gaining employment (Quigley 1995). In addition, the attitude of health professionals impacted upon disabled people when receiving health services. Some health professionals had limited knowledge of how to assist disabled people which resulted in them becoming offended in providing assistance and not wishing to provide further services to
disabled people (Tighe 2001). The attitude of non-disabled people also has impacted on disabled people in receiving help from them when they encountered difficulties in the community (Tighe 2001). Even though these studies were able to show some people's attitudes towards disabled people, they were conducted in Western cultures.

In Eastern cultures, both positive and negative attitudes of non-disabled people towards disabled people were found. In the study of Bakheit and Shanmugalingam (1997) who used the Scale of Attitudes toward Disabled Persons to examine the attitude of 111 rural Indian people, people had positive attitudes towards disabled people (Bakheit and Shanmugalingam 1997). On the other hand, Nagata (2008) using the same tool to examine the attitude of non-disabled people in Jordan and Lebanon found a negative attitude towards disabled people. However, these studies relied on a non-disabled group's self-report of their attitudes, so they might not have captured attitudes towards disabled people as shown in everyday practice. The attitude of Thai people towards disabled people was explored in the study by Panyamee (2005), and Naemiratch, and Manderson (2009). They found that disabled people experienced both positive and negative attitudes. Participants in the study by Panyamee (2005) reported that the negative attitude of people in the community prevented them from participating in the community and having the same right as others whilst positive attitudes of people in the community supported them to participate actively in the community and exercise their rights (Panyamee 2005).

When attitudes towards disabled people were compared between Western and Asian students in a study by Chen et al. (2002), American students were found to have a more positive attitude towards disabled people than Taiwanese and Singaporean
Students. Comparisons have also been undertaken in the attitudes of rural and urban people towards disabled people. Palmer et al. (2000) examined the attitudes of rural and urban students and found that both student groups had positive attitudes towards disabled people. However, their study included students in human service professions such as physical therapy, occupational therapy, and nursing. It was possible that these students would likely have a more positive attitude toward disabled people than students from other disciplines.

Mobility has also been reported as an important factor in achieving or maintaining independence (Hill 1993). In many studies, physical barriers were found to prevent disabled people from accessing the community, therefore, reducing their community integration (Mcmillan and Soderberg 2002; Meyers et al. 2002; Paul 1999; Tighe 2001). A survey by Kovindha (2000) of architectural barriers in urban areas of Chiang Mai province, Thailand, and an interview by Panyamee (2005) of 13 Thai disabled people found similar results. Physical barriers included inaccessible houses, public and private buildings, deep street curbs, and indoor physical barriers such as small elevators and stairs. Crowding in public places also hindered people's lifestyles because jostling often resulted in disabled people becoming afraid of falling (Stephens and Yoshida 1999). Furthermore, for people who could no longer drive, transportation was recognised as a significant component of independent living (Bowe 1979; Brown et al. 2002; Froehlich et al. 2002; Stephens and Yoshida 1999). For example, in the study by Stephens and Yoshida (1999), lack of accessible transportation was reported as having an impact on a person's ability to gain access to and maintain activities in the community. This was in line with the study in Thailand (Panyamee 2005).
Finally, financial resources are an important factor in enabling disabled people to live independently. West et al. (1995) noted that the availability of financial resources was often cited as a factor in obtaining control over decisions, whilst a lack of financial resources was often cited as an inhibiting factor for gaining control. Without financial resources, disabled people were not able to choose their preferred options for equipment, assistance or support. For example, in the study by Froehlich et al. (2002) and the study by Pluym et al. (1997), finance was identified as a factor that hampered disabled people from participating in leisure activities in the community such as hobbies, clubs and going out. Barnes (2007) also stated that financial resource in the form of direct payments for personal, social, and domestic services for disabled people was a key to independent living. It enhanced the disabled people’ self-esteem and self-confidence, relieved pressure on family members, and provided disabled people with more opportunities to participate fully in the community. The impact of financial resources on disabled people in the Thai community was also studied by Panyamee (2005). Whilst a lack of financial support prevented her participants from having control over decisions, doing what they wanted, participating in the community, and exerting their rights in the community, financial security enabled them to have control over decision, their lives and allowed them to actively participate in the community (Panyamee 2005).

In summary, whilst disability and the independent living concept in the West were reviewed in Chapter 1 and Chapter 2, this chapter presented a broad picture of disability in Thailand and the development of independent living in Thailand. It also described a situation where changes in the family and communities led to a greater role for the government and its plans. Even though, independent living for disabled
people seems to be individual responsibility, the role for society beyond individual remains important. This research was open to finding similarities and differences around the independent living issue for those living in Thailand compared to living in the West. Similarities and differences would be useful information for implementation of independent living in Thailand.

3.4 The Significance of the Study

As mentioned previously, the concept of independent living spread throughout the world including Thailand. Also, independent living for disabled people was set up as a goal of the Thai national plan on disability (Office of the National Economic and Social Development Board 2006a, b). However, the independent living concept was generated from Western or individualistic culture. Thailand seems to have a more paternalistic view of disability than the West. Additionally, most disabled people in Thailand are confronted with poverty and live in rural areas where there are not enough support services provided. These lead to questions as to whether the concept of independent living is appropriate to implement in a Thailand.

The application of the ICF in clinical research and clinical practice in rehabilitation all over the world including Thailand is a mechanism for promoting independence in disabled people. The ICF acknowledges activity and participation, and also highlights how personal and environmental factors serve as barriers or facilitators to activity and participation for individuals and groups of individuals (World Health Organization 2001). Therefore, being disabled but independent and an active member of society seem to be a common aim between the ICF and the independent living concept.
To promote independence in disabled people in Thailand as shown in the ICF and the independent living concept adopted by the Thai government, an understanding of the issues concerning independence on the part of all stakeholders is required. As people with physical impairments are the majority group of disabled people in Thailand (Office of Empowerment for Persons with Disabilities 2007) and their lives are limited more than other groups, they should be the first group encouraged to be independent. Previously, the perspectives of 13 Thai people with physical impairments and their significant others were investigated (Panyamee 2005). However, there is no study exploring the opinions of health professionals in Thailand.

Even though, it has been confirmed that occupational therapy could work in line with an independent living concept which is based on the social model of disability (Bowen et al. 1993), it is obvious that many health professionals work under the influence of the medical model of disability (Hammell 2006) whereby impairments are the field of interest rather than disabled person's concepts of independent living. In Thailand, the study of Pongsaksri (2004) indicated that Thai occupational therapists also provided their services based on the medical model. Therefore, it would seem to be necessary to investigate Thai occupational therapists' understanding of independent living and whether their level of understanding is adequate in order for them to be able to support disabled people in Thailand to be independent.

The independent living concept generated from Western culture is already implemented to an extent in Thailand despite the differences in culture, economic, and support service systems from Western countries. Furthermore, there is evidence to show that Thai disabled people recognise the significance of independent living
(Panyamee 2005) and also feel it is possible for them to be independent (Sungrugsa et al. 2008). Iwama (2007) feels that culture is fundamentally important to occupational therapy which should view understanding of culture as preeminent in its promise; to enable people to engage in activities and processes that they value within their own environment. Thus it would seem to be important to consider the concept of independent living within a Thai cultural context.

In summary, whilst disability and the independent living concept in the West were reviewed in Chapter 1, this chapter presented a broad picture of disability in Thailand and the development of independent living in Thailand. It also described a situation where changes in the family and communities led to a greater role for the government and its plans. Even though, independent living for disabled people seems to be an individual responsibility, the role of the wider society remains important. This research aims to explore the views of and perspective on independent living of Thai occupational therapists. Any similarities or differences identified between the Western and Thai understanding of independent living highlighted in this study via the occupational therapists’ views, would be useful information when considering the more general issue of attempting to implement independent living in Thailand.
Chapter 4

Methodology

Previously, the concept of independent living was reviewed. This chapter describes the conceptual framework and methodology used in this study. It includes a rationale for using a qualitative research approach and describes the research process from data collection to data analysis. In addition, this chapter presents the strategies used to accomplish scientific rigour.

4.1 Research Design

In order to explore occupational therapists' opinions on the issue of independent living, this study was designed using qualitative method for two reasons. Firstly, qualitative methods facilitate the study of issues in depth and in detail (Patton 2002). It enables researchers to understand and capture the points of view of other people, and allows the participants' world to be studied in context and the findings to be embedded in their reality (Patton 2002). As this study aimed to investigate Thai occupational therapists' opinion about what independent living means to them, the feasibility of independent living in Thailand, and the models and strategies for practice supporting independent living, the qualitative method enabled me to explore and understand their experiences and opinions about these issues.

Secondly, qualitative methods are advocated when little is known about the phenomenon being investigated and where the social contexts are of critical significance in understanding the phenomena (Rice and Ezzy 1999). In Thailand, even though independent living has been adopted for two decades, it has been recognised
only among some groups of disabled people. Additionally, Thai occupational therapists normally base their practice on the medical model (Pongsaksri 2004), rather than the social model of disability. Furthermore, the independent living concept is generated from Western practice and when developing a model and guidelines, cultural differences begin to emerge. Hence, it is crucial to build a deep understanding about the culture specific issues. It is necessary to listen to the opinions of what independent living means to Thai occupational therapists, whether the independent living concept is feasible for disabled people in Thailand, and what and how occupational therapy services should be provided in order to give support to independent living. Such data could allow me to obtain a comprehensive picture of Thai occupational therapists’ understanding and their practice before further development of a standard model and guidelines for practice in Thailand.

4.2 Qualitative Methods Used in the Research

Interviewing is one of the most common and powerful ways for understanding human beings (Fontana and Frey 2000). It includes a wide variety of forms and a multiplicity of uses. One form of interviewing is an in-depth interview. An in-depth interview allows researchers to understand the perspectives of people who have directly experienced the phenomenon of interest (Patton 2002). In-depth interview allows interviewers to have more time to discuss topics in detail, gives full attention to interviewees, and the interviewing style can be adjusted to suit the interviewees (U.S. Department of Health & Human Services [no date]). Even though in-depth interview seems to be appropriate in this research due to its advantages, it has some limitations. It is important that face-to-face interviews are an emotionally reactive experience for both interviewers and the interviewees. This is stressed in the methods literature
where empowering research participants is discussed (Mishler 1986) and where interviewers are described as "problematic" as "located practice" (Wengraf 2001). Hence one source of difficulty with an interview method would be "evaluation apprehension" (Henchy and Glass 1968). Since I am likely to be known as a professional trainer and a professional colleague, the encounter might be perceived as a risk to the interviewee, if certain values are expressed. Hence, although delving deeply was important for the research, it was necessary to consider another method which was far more collective and collegial than individual interview.

Another interesting form of interviewing is a focus group interview. From the literature on group methods, the focus group is a collectivistic research method that focuses on the multivocality of participants' attitudes, perceptions, opinions, and experiences (Krueger 1994; Madriz 2000). The focus group is highly appropriate when researchers need to observe interaction within the group based on topics that are supplied by the researchers (Madriz 2000; Morgan 1997). Therefore, this method was appropriate to use for collecting data from groups of Thai occupational therapists for exploring their opinions and experiences on the issue of independent living. It also allowed me to understand their ways of thinking and, with reference to participants, how such ways of thinking emerged.

Focus group interviews had several advantages for the research. Firstly, data collection was cost-effective and less time consuming compared to individual interview (Krueger 1994; Patton 2002) because it allowed me to interview several people at once (Kitzinger 1999). In addition, as each group comprised several interviewees, there was less risk of the interviewees avoiding a topic because of
evaluation apprehension. Secondly, as participants in this study already knew each other through studying, working, and socialising together, the discussion groups were able to run smoothly in an accommodating environment (Kitzinger 1999). Thirdly, interaction among participants was able to enhance data quality because participants tended to provide checks and balances on each other (Patton 2002). Participants were influenced by others’ comments and made decisions after listening to the advice and counsel of people around them (Krueger 1994). This helped keep issues important for occupational therapists within the scope of the study without my interference. Even though I had less control when compared with an interview method, it did not mean that I could not lightly structure group discussion. It is stated that the nature of a focus group allows a researcher to probe in order to explore unanticipated issues (Krueger 1994). This was a benefit for me because it allowed exploration and more understanding of the issues when the participants raised unexpected ideas.

The method of choice in this research was focus group interviews that I wanted to carry out in all parts of Thailand. However, I was unable to hold focus group interviews in the South because of the Tsunami that has just occurred when the study was carried out. It was distinctly possible that occupational therapists from the South might not be able to join the research because they were bound up with providing services to the Tsunami’s victims. Therefore, I held the groups, then reconvened the groups and used the two participants from the south who were able to take part to evaluate the issues raised in the focus groups.
4.3 Method

The purpose of this research was to explore occupational therapists’ understandings of the significance and feasibility of independent living. Additionally, the research aimed to identify the appropriate models of practice and explore strategies for practice for Thai occupational therapists in order to enable them to support independent living for people with physical impairments. As the location of the research was in Thailand, the research proposal was reviewed and approved by the ethics committee of the Faculty of Associated Medical Sciences, Chiang Mai University, Thailand. The research process was monitored by the researcher and her academic supervisors. The Department of Occupational Therapy Education at the School of Healthcare Studies, Cardiff University supported the necessary facilities and equipment for this research. The following paragraphs provide details of participants, sampling, procedure, data collection, data analysis and credibility of the research.

4.3.1 Participants and Sampling

Thai occupational therapists were invited to participate in this research as the research sought to explore their experiences and opinions on the issue of independent living. Patton stated, “there are no rules for sample size in qualitative inquiry” (Patton 2002: pp. 244). Sample size depends on the aims of study, the purpose of the inquiry, the credibility of data generated, and available time and resources (Patton 2002). As there was limited time and financial support for this research, 26 occupational therapists were recruited to provide information for the research. However, this number allowed the research to achieve data saturation.
Purposive sampling was used to select potential people for the research. It focuses on selecting information-rich cases whose input illuminates the questions under study (Patton 2002). Two types of purposive sampling were conducted in this research. In the first stage, criterion sampling was used to select occupational therapists who met the initial criteria including having at least four years working experience with people with physical impairments. In order to select interviewees, the second stage used maximum variation sampling to include a diverse range of occupational therapists according to geographic areas, the types of workplace and experience in community work. Through maximum variation sampling, I was able to avoid one-sidedness of representation of the research (Patton 2002).

4.3.2 Procedure

This section describes the ethical procedure and research procedure.

4.3.2.1 Ethical Procedure

As is similar to other research involving humans, ethical approval to perform the research was required. As the research project sought to investigate the opinions of Thai occupational therapists, the ethical clearance needed to be carried out in Thailand. In Thailand, there are two channels for obtaining ethical approval. The first channel is an application for ethical approval being sent to the ethics committee of the Ministry of Public Health. The other is an application for ethical approval to any university in Thailand. As I work in Chiang Mai University, the research project was sent to the ethics committee of the Faculty of Associated Medical Science, Chiang Mai University in order to obtain ethical clearance. All documents including the
research project, the participant information sheet and consent form were prepared in Thai for consideration.

4.3.2.2 Research Procedure

After ethical clearance for the project was gained, an initial questionnaire (see Appendix 1) was mailed to 250 occupational therapists who were on the database of the committee of occupational therapy license. The initial questionnaire was used to gather information from occupational therapists for the research. Three weeks after the mail out, the information from the returned questionnaires was used to select occupational therapists who met the inclusion criteria. They were then asked to participate in the research. Those who were interested in taking part in the research were asked to contact me directly within three weeks. For their convenience, I offered them three methods of contact including returning a postcard, making a telephone call, or sending an electronic mail. I selected the most diverse occupational therapists in order to achieve maximum variation. For people who expressed their interest but were not selected or not able to join focus groups, they were not excluded from the research. They were thanked and invited to provide additional comment to the summary from the focus groups. The number of occupational therapists who responded to each step is shown in Table 4.1 whilst Table 4.2 presents participants' demographic data including career, education, work experience, working area, type of workplace, and experience in the community.
Table 4.1 The number of Thai occupational therapists responding in each step

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responses</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing out the questionnaire</td>
<td>No recipient – mail returned</td>
<td>8</td>
</tr>
<tr>
<td>(250)</td>
<td>Returning the questionnaire</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td>Not returning the questionnaire</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>(250)</td>
<td></td>
</tr>
<tr>
<td>Selecting occupational therapists who met the</td>
<td>Meeting the criteria</td>
<td>55</td>
</tr>
<tr>
<td>criteria</td>
<td>Not meeting the criteria</td>
<td>97</td>
</tr>
<tr>
<td>(152)</td>
<td>(152)</td>
<td></td>
</tr>
<tr>
<td>Advertising the research project (55)</td>
<td>Expressing interest in the project</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No interest in the project</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>11</td>
</tr>
<tr>
<td>Recruiting participants to the research</td>
<td>Being selected</td>
<td>26</td>
</tr>
<tr>
<td>project (29)</td>
<td>Not being selected or not able to join</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>focus group</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.2 Participants’ demographic data

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Variations</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career</td>
<td>Occupational therapists</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Occupational therapists involving</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>academic</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>PhD Degree</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Master Degree</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Bachelor Degree</td>
<td>16</td>
</tr>
<tr>
<td>Work experience</td>
<td>(4-20 years)</td>
<td></td>
</tr>
<tr>
<td>Working area</td>
<td>North (including OT in academic area)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>North-East</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Central</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>2</td>
</tr>
<tr>
<td>Type of workplace (both current workplace and workplace in the past)</td>
<td>Hospital attached university</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Regional hospital</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>General hospital</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community hospital</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Private hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Miscellaneous</td>
<td>8</td>
</tr>
<tr>
<td>Experience in the community</td>
<td>Yes</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

In this study, 26 participants were willing to provide information to the research. From these numbers, four occupational therapists were also in academia. All participants had graduated from Chiang Mai University, Thailand. 10 of all participants had higher education in occupational therapy (Master, PhD. Degree from abroad) and other disciplines related to occupational therapy (Master Degree in Thailand). Most participants worked in the North whilst there were few occupational therapists from the South who returned the initial questionnaire, and only two occupational therapists met the inclusion criteria. Most of the participants provided services in large hospitals including hospitals attached to a university, regional hospitals, and others (rehabilitation centres and specialised hospitals). There were no
occupational therapists who met the inclusion criteria with respect to working in a community hospital. However, 24 of all participants had experience in working in the community (see Table 4.2). Their work experience as an occupational therapist ranged from 4 to 20 years. All of them were involved mostly with physical disabled people.

After recruiting the participants to the research, I sent them an information sheet about the research (see Appendix 2). As it was stated that to enable occupational therapists without disability to better understand the disability experience, occupational therapists should search to grasp clients' experience and listen to what clients presented their disability and their lives (Franits 2005). Therefore, to enable the participants to fully discuss independent living, I provided them with information of independent living and a summary of Panyamee's (2005) study which was about the perspectives of Thai disabled people on independent living in Thailand (see Appendix 3). Focus groups were used to interview most participants whilst the two participants from south Thailand were individually interviewed after the focus groups were finished. A safe and convenient place was arranged for each group but the time was decided by the participants. A letter confirming the date, time and venue for each focus group discussion and interview was sent to the participants. This was followed up by a telephone call reminding them of the sessions and confirming their intention to attend. All participants provided written consent (see Appendix 4) when they attended the interviews. Table 4.3 showed the summary of research design, participants, and timescale.
### Table 4.3 The summary of research design, participants and timescale.

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research design</td>
<td>Qualitative study using focus group and individual interview</td>
</tr>
<tr>
<td>Sampling technique</td>
<td>Purposive sampling: criterion and maximum variation sampling</td>
</tr>
<tr>
<td>Pilot focus group</td>
<td>8 participants who were the 4th year occupational therapy student, Chiang Mai University</td>
</tr>
</tbody>
</table>

**Fieldwork**

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>First group</td>
<td>Re-convened group</td>
</tr>
<tr>
<td>North group</td>
<td>8</td>
</tr>
<tr>
<td>Central group</td>
<td>8</td>
</tr>
<tr>
<td>North-east group</td>
<td>4</td>
</tr>
<tr>
<td>Academic group</td>
<td>4</td>
</tr>
<tr>
<td>Individual interview</td>
<td>2</td>
</tr>
</tbody>
</table>

Timescale: June to October 2005

**4.3.3 Data Collection**

Morgan (1998) states that less structured groups are most appropriate when a project aims to explore participants’ thinking. In this research, a less structured approach was used in focus groups because it allowed the participants to express their experience on the determined issue. My role as the researcher was to facilitate discussion. This strategy allows discussion to move from broader to narrower topics (Morgan 1998). Beginning with a broad question the participants expressed their own thoughts on the research topic while later questions allowed discussion that was more central to the research topic (see Appendix 5). I provided minimum involvement while encouraging all participants to discuss. Modifications to the sequence and wording of questions were made on the basis my experience from a pilot focus group, which was previously...
undertaken with fourth year occupational therapy students in the Department of Occupational Therapy, Faculty of Associated Medical Sciences, Chiang Mai University. In addition, an observer who had experience with conducting focus groups was invited to attend the pilot focus group in order to provide comments for me.

At the commencement of focus group interviews, participants were welcomed and an overview of the topic, ground rules, and my role as a moderator were given. All participants were reminded of the confidentiality of their discussions. Three examples of life experiences of disabled people in Thailand were used to facilitate discussion (see Appendix 6). Each interview ranged from one to two hours in duration and was conducted in Thai. To prevent a narrow focus of data gathered from occupational therapists due to limited time, each focus group was reconvened in order to explore opinions of participants in depth and detail (Patton 2002). All interviews were audiotaped and transcribed verbatim as soon as possible following the interviews.

In focus groups, Krueger (1998) recommends using an assistant moderator for taking comprehensive notes, operating the tape recorder, handling environmental conditions and logistics, and responding to unexpected interruptions. Having an assistant is stated to increase both the total accumulation of information and the validity of the analysis (Krueger 1998). However, it was difficult for this research to have an assistant moderator that was able to accompany me from place to place in order to conduct the focus groups. Therefore, a guideline of conducting focus groups for the moderator (see Appendix 7) was used in the research. Even though this strategy might not fully substitute for the role of an assistant moderator, it allowed me to record group dynamics without an assistant moderator. My experience, behaviour of the
group, and any other relevant observations or reflections were recorded as field notes after each interview. The use of such notes provided a means of taking into account personal reactions to the discussion groups.

When conducting the individual interviews with the participants from the south, the same series of open-ended questions was used. Additional questions and prompts were also used during the interviews to explore greater depth of issues raised by participants. Similar to focus groups, interviews ranged from one to two hours in duration. Interviews were audiotaped and field notes were made after each interview.

After focus groups and individual interviews, I sent the draft reports back to the participants to check the summaries or particular understandings or variation in reporting for verification. The participants were invited to provide feedback by writing on the draft focus group summary. In addition, in response to occupational therapists who expressed their interest but were not recruited or not able to participate in focus groups, the summary of findings from all focus group interviews was sent to them in order to allow them to provide additional comments.

4.3.4 Data Analysis

To provide an understanding of the way that occupational therapists think about how to support disabled people to achieve independent living, it is necessary to consider how data would be analysed. In this study, the analytic induction approach was used for analysing data.
The analytic induction approach begins with specific observations and builds towards general patterns (Patton 2002). Categories or dimensions of analysis emerge when the researcher comes to understand patterns that exist in the phenomenon being investigated (Patton 2002). In this study, information from occupational therapists was elicited using a particular case and an initial hypothesis was derived which attempted to explain participants’ opinion. One by one each case was then compared to the hypothesis, to see whether they confirmed or refuted it. The hypothesis was refined or revised if there were “deviant cases” (Bloor 2001: pp. 66).

Content analysis using transcript-based analysis and systematic coding based on the work of Krueger (1994) were used to analyse data. Traditionally, researchers carried out the mechanics of analysis by hand (Weitzman 2000). However, a wide variety of useful computer software programs are now available to support many different approaches to qualitative research. As this research contained a large amount of information from focus groups and individual interviews, a computer software program, NVivo 7 which is designed for many languages including Thai, was used in order to enable me to manage data more easily. With this program, organising data could be carried out easily by highlighting key points and assigning codes to them. It allowed me to quickly track key points and collate them later. In addition, the program allowed me to edit and annotate research documents after they were imported. Creating memos to capture more detailed thoughts, and link them to research documents also could be done. Furthermore, the program allowed me to explore and query evidence about relations between items, processes and people.
In the first step, I coded the major points and significant meaning or emerging themes based on each probe question. These formed the first categories and the relevant key quotes and/or statements relating to each category were recorded (Coffey and Atkinson 1996). Then, I selected quotes, which were within mainstream perspectives and in line with the objectives of the study (Krueger 1994). In the second phase, the emerging categories from all questions were coded and the number of times the key categories were reported was automatically counted by the program. The coding methods enabled me to recognise the persistent words, phrases, themes or concepts within the data (Field and Morse 1985). It also enabled me to review what data were saying (Coffey and Atkinson 1996). A label was attributed to each new idea or phenomenon, with the same label being used each time the concept/phenomena reappeared, even if it was presented in different words and styles (Krueger 1994). In the third phase, the themes were identified from the developed major categories. Each theme was named according to its significant content and meaning (see Appendix 8). Then, I summarised the findings according to the objectives of the study and then wrote the draft reports starting with the most important questions or major theme.

4.3.5 Rigour

The term rigour is used in qualitative research to refer to strategies used to increase the credibility of the research. Rigour aims to minimise the effect of subjectivity on the qualitative process including research design, data collection, and analysis of data (Rice and Ezzy 1999). Rice and Ezzy proposed five factors for ensuring rigour in qualitative research. These are theoretical, methodological, interpretive, evaluative, and reflexivity rigour.
4.3.5.1 Theoretical Rigour

A qualitative study has theoretical or conceptual rigour if the research strategy is consistent with the research goals (Rice and Ezzy 1999). Theoretical rigour aims to ensure that a study uses methods appropriate to the theoretical basis used to frame and investigate the research problem (Rice and Ezzy 1999). In this research, several strategies were applied to the research project to achieve theoretical rigour. The first strategy was in design the study. Patton (2002) proposed that using naturalistic inquiry allowed real world situations to be studied without manipulation and control. In this research, a less structured approach and open ended questions were used when conducting focus groups and individual interviews. Throughout this less structured approach, I took the role of moderator or interviewer that encouraged participants to discuss rather than seek control over discussion. This allowed participants to express their thoughts about independent living without predetermined constraints on their experiences. However, focus group interviews typically have a disadvantage of taking place outside of the natural setting where social interactions normally occur (Madriz 2000). This problem was alleviated because participants in this study already knew each and, consequently, the discussion groups were run smoothly in an accommodating environment (Kitzinger 1999).

Secondly, Mason (1996) proposed that sampling strategies enabled a study to achieve theoretical rigour if the data sources selected, such as people or documents, had the potential to answer the research question. In this study, several sampling strategies were used in order to identify occupational therapists who were representative of people who were appropriate to answer the research questions. Criterion sampling was used, firstly, to select occupational therapists who met the determined criteria. In
addition, a diverse range of people was purposefully sampled using a variety of inclusion criteria in order to explore the breadth of experiences of occupational therapists. These sampling methods were undertaken in order to recruit participants who were considered to be information-rich cases and were generally representative of the population of occupational therapists, therefore, enhancing the credibility of the data collected.

Thirdly, peer review has also been cited as a way to achieve theoretical rigour (Goodwin and Goodwin 1984). This research was monitored by two academic supervisors who provided recommendations and feedback regarding the trustworthiness of this study.

4.3.5.2 Methodological Rigour

Methodological rigour can be maintained if qualitative researchers provide a detailed account of how the research is conducted (Rice and Ezzy 1999). In this study, methodological rigour was achieved in a range of ways, including gaining quality data, careful reviewing by a reference group, keeping an audit trail of my personal experiences of the research (i.e., field notes), and the use of triangulation techniques and member checking.

To gain quality data, four focus groups (three groups from each geographic areas and one for people who work in academia) were conducted. Kreuger and Casey (2000) recommended at least three focus groups are required in order to gain enough data for comparing and contrasting. Therefore, conducting four discussion groups enabled me to satisfy methodological requirements. In addition, each group was reconvened so
that I had enough time with participants for achieving maximum information, and group discussion.

The reference group provided the means of monitoring procedures and discussing decisions. Meetings between my academic supervisors and I were carried out regularly in order to discuss concerns and perceptions and to reflect on the rigour of the methodology. The academic supervisors also reviewed data collection and analysis both prior to and following translation from Thai to English.

According to Patton (2002), personal experiences and insights are an important part of the inquiry and critical to understanding the phenomenon. I am an occupational therapist which might enable participants to feel that they were talking to a person who had had similar experiences to them and allowed them to feel free to provide information for the research. In addition, it also enabled me to gain a deeper understanding of participants' experiences and opinions. However, keeping an audit trail throughout the research process also enabled me to separate my own perceptions and experiences from those of the participants.

Another technique used for achieving methodological rigour is triangulation (Rice and Ezzy 1999). The concept of triangulation is based on the premise that no single method adequately solves a problem (Patton 2002). There are four types of triangulation including data triangulation, investigator triangulation, theory triangulation, and methodological triangulation (Denzin 1978). This study used methodological triangulation. Using focus groups and individual interviews could provide a useful data set for further understanding in the study. In addition,
information from the checklist for a moderator and field notes were able to enhance the trustworthiness of findings by providing information about group dynamics and the context of the people who were interviewed.

4.3.5.3 *Interpretative Rigour*

Qualitative research has interpretative rigour if it accurately represents the understandings of phenomena of the people engaged in them (Rice and Ezzy 1999). Accuracy and trustworthiness of interpretations in this study were facilitated by member checking. Written transcripts of the discussion were sent to all the participants in each group to elicit their opinion on the accuracy of the transcription and to check whether any relevant information was omitted. In addition, I sent the draft reports back to the participants to check the summaries, particular understandings or variations in reporting for verification.

According to Patton (2002), in order to achieve interpretative rigour, individual analysis should be undertaken prior to cross-case analysis. In this study, data from each focus group were assessed and crosschecked between and within groups.

In addition, this research also used other methods to enhance interpretative rigour. Firstly, in reporting the research, substantial parts of interview transcripts were translated into English and checked by supervisors who were native English speakers. Then, they were directly quoted to support the analysis. Research memos were used to discuss evolving perceptions with supervisors. Furthermore, the content of the interviews and emerging themes were reviewed by an independent investigator as
well as supervisors. Then, these themes were discussed and consensus was reached on
the terms to be used and their definitions.

4.3.5.4 Evaluative Rigour

Evaluative rigour involves ethical and political aspects relating to research procedures
(Rice and Ezzy 1999). In this study, the ethics committee of the Faculty of Associated
Medical Sciences, Chiang Mai University granted approval for this research to be
conducted. This research also received approval from the committee for occupational
therapy license to access the occupational therapist database.

4.3.5.5 Reflexivity Rigour

Reflexive rigour examines the researcher’s role in the research process (Mason 1996).
Reflexivity reminds the researcher to be attentive to and conscious of the culture,
political, social, linguistic, and ideological origins of one’s own perspective and voice
as well as the perspectives and voices of interviewees and those to whom one reports
(Patton 2002). In this study, the research memos were used to record my feelings and
thoughts throughout the research process. At times, these thoughts and feelings were
discussed with supervisors to provide an opportunity to reflect on values and
assumptions, and to discuss whether these were impacting on the data collection and
analysis. A more detailed discussion of my own stance is provided next.

4.4 Researcher’s Stance

Before studying at Cardiff University, I was an occupational therapist working as a
lecturer at the Department of Occupational Therapy, Faculty of Associated Medical
Sciences, Chiang Mai University, Thailand. I hold a Bachelors Degree granted in
1989 and a Master of Philosophy in Occupational Therapy granted in 2005. According to my qualification and work experience, I brought an insider perspective to the research in several respects. Firstly, through my background, I noted that current occupational therapy theories have been developed in a Western context and were based on values and assumptions implicit to Western lifestyles. This resulted in my interest in conducting research about issues related to occupational therapy practice in the Thai context. Previously, my research experience included undertaking survey research regarding activities using the upper extremities in order to develop an upper extremities performance test for the Thai elderly, and an investigation of the discriminative power of Lowenstein Occupational Therapy Cognitive Assessment (LOTCA) in Thai patients with acquired brain injury. Therefore, I came to this research with an understanding of the importance of undertaking research within the Thai context to investigate the relevance of Western concepts regarding disability. In particular, I was interested in developing a better understanding of the perspectives of people with acquired physical impairments in the current status of independent living in Thailand (Panyamee 2005). I anticipated that an understanding of the life experience of Thai disabled people could be used to inform occupational therapy practice in order to support independent living for people with acquired physical impairments. Secondly, my professional background as an occupational therapist and academic enabled me to better understand participants' opinions on the issue of independent living. However, I realised that it also might lead participants to view me as an authority figure and this might prevent them from feeling free to talk to me about the issue of independent living. Therefore, in order to reduce such a perspective, I tried to provide a friendly environment and take a facilitator role when conducting interviews. Lastly, my experiences as a Thai person enabled me to gain a deeper
understanding about participants' experiences within the Thai context regarding culture, religion and resources.

However, I also took an outsider's perspective to the research. The fact that I am a disabled person who has a left leg weakness from polio might have prevented participants from fully discussing disabled people's lives. However, my impairment is not severe and I present myself as a disabled person who can live independently. This allowed participants to feel more comfortable when expressing their experience on disabled people's lives.

The process of research can also influence the perspective of the researcher. Prior to undertaking the research, I had believed that the majority of occupational therapists in Thailand lacked an understanding of the independent living concept. This was because the independent living concept was not part of the occupational therapy curriculum. During the research, I began to understand Thai occupational therapists' experiences and opinions regarding the independent living issue. As the research progressed, my understanding of their experiences and opinions was expanded. As expected, I found that some participants interpreted independence as functional ability, which is based on the medical model of disability. However, some participants had a good understanding about independent living issues. This showed me that knowledge about the independent living concept was required for occupational therapists involved with disabled people engaged in independent living. Even though some participants did not define independence correctly, all participants realised that promoting independent living in disabled people in Thailand was their responsibility.
In addition, I initially felt that occupational therapists in Thailand provided limited services only in institutions. This resulted in disabled people in the community not being able to adapt themselves and live independently. However, I found that occupational therapy services had begun to expand into the community. Some participants provided support for disabled people in order to enable them to live in the community whilst some participants spent most of their time rehabilitating clients. I also noticed that collaboration between participants and disability organisations was established. I also realised that some participants had acknowledged the importance of disabled people living in the community and had expanded their services from hospitals into the community in order to assist these people. Additionally, I gained a deeper understanding of the supports and barriers connected with independent living. From the participants’ viewpoint, I realised that disabled people needed to be empowered through information, the support of other people, financial support and government legislation and structures to achieve independence. I also obtained strategies for practice and appropriate models of practice giving support to independent living.

After hearing similar things from a number of participants, my understanding of independent living in the Thai community began to develop. This challenged my own perspective, which had developed through training and experience in rehabilitation. It also provided the basis for the development in the future of standard strategy to support the practice of occupational therapists in facilitating independent living in the Thai community. In addition, this research enabled me to undergo a major shift in my thinking towards a broader view of the independent living issue. Not only occupational therapists, but also other health professionals, such as those working in
the Thai government, disability organisations and the community, have to understand the needs of disabled people and take supporting roles that facilitate these people to achieve independent living. In order to maximise the benefit of the research, a report on the completed study will be sent to the Occupational Therapist Association of Thailand. In addition, the completed study will be submitted for publication into a relevant journal.
Chapter 5

Expanding on the Theory of the Research

Previously, the conceptual framework and methodology used in the study were explained. This chapter aims to expand on the theory of the research detailed in Chapter 4. This chapter presents my own opinions and feelings on methodology of the research regarding research method, interview questions, the pilot focus group, and the main study.

5.1 Research Methods

To gather information to the research, I decided to use both focus groups and individual interview because both methods enabled me to understand participants’ opinions and experiences about the independent living issue. Even though each method can be used separately, using them together can strengthen a research design (Morgan 1997). In this study, focus groups were used to gather information from most participants because it enabled me to interview several participants at once. As participants worked in different provinces in Thailand, interviewing each participant was felt to be time and budget consuming. Interaction within the focus groups was also another factor influencing me to select focus groups for interviewing most participants. The interaction within the focus groups enabled me to obtain insights into participants’ opinions and experiences about the independent living issue. Participants in the group had opportunities to share their opinions and experiences with each other. I felt that it enabled me to obtain data efficiently. In addition, I felt that the role of moderator in the focus groups allowed participants to feel free to
discuss their opinions and experiences rather than feeling apprehension as a result of my professional experience.

Whilst focus groups were used with most of participants, individual interviews were used when insufficient participants agreed to take part since there were only two occupational therapists from the south participating in the research. Even though individual interviews enabled me to understand participants’ opinions and experiences about the independent living issue, I realised that my professional experience might cause participants to feel uncomfortable to discuss the issue. Therefore, to allow participants to feel free to talk about the independent living issue, participants were informed before interviews that their opinions and experiences would be respected and there were no right or wrong answers.

When considering the sequence of interviews, I decided to conduct focus groups first and then follow with individual interviews. Morgan (1997) stated that following focus groups with individual interview allowed researchers to obtain depth and detail on topics that were only broadly discussed in group interviews. However, in this research there was little new information from individual interviews. This was a consequence of this study that was designed to have reconvened focus groups in order to explore the opinions of participants in-depth and in detail.

When conducting the focus groups, participants from the same geographic areas were invited to join the same focus groups (North, North-East, and Central). This was because I felt that participants from the same geographic areas might have common experiences about disabled people’s lives. With homogeneous participants in term of
geographic areas, I thought that the independent living issue was explored in greater depth. For participants who worked in an academic area, I set a focus group interview for them separately from other participants in order to allow other participants to feel free when discussing issues. Hence, there was a total of eight focus groups conducted in this research. According to Morgan (1997), data from at least three focus groups are required in order to compare and contrast data. Based on this statement, it is assumed that this research had an adequate number of focus groups for saturation of data. Even though it is stated that there is a need to evaluate whether further focus group are required after three groups have been conducted (Krueger 1994), I did not evaluate this because the research was aimed at exploring opinions and experiences of a diverse range of Thai occupational therapists. Therefore, the number of focus groups in this research was determined at the beginning according to the variation in geographic area and the types of workplace (six focus groups for participants from the North, North-East, and Central, and two focus groups for participants who are involved in academia).

In this study, the number of participants participating in focus groups ranged from four to eight which depended on the number of participants in each geographic area. Even though there is no absolute ideal in terms of the number of participants, six to ten participants are the norm (Krueger 1994; Morgan 1997), four to twelve people is acceptable (Krueger 1994). In this study, even though groups of four participants seemed to be small, all participants in the groups had a high level of involvement when they were asked to talk about the independent living issue.
5.2 Questions

The interview questions were designed as funnel questions, which meant they were asked from general to specific, from broad to narrow. Firstly, participants were asked “What do you think about independent living’s information and the case examples provided?” This question encouraged them to talk and also enabled them to link the case examples with their own experience about disabled people in Thailand. I thought that beginning with this question helped establish a context for participants to express later. Whilst the first question encouraged participants to talk and showed their experiences on disabled people in Thailand, the later questions were designed to explore their feelings and opinions about the independent living issues more specifically.

5.3 The Pilot Study

It is stated that a pilot study should evaluate the ability of the questions to draw out the participants (Krueger 1994). As mentioned in the previous chapter, this study had a pilot focus group comprising fourth year occupational therapy students in the Department of Occupational Therapy, Faculty of Associated Medical Sciences, Chiang Mai University. Not only did this enable me to modify the sequence and wording of interview questions, it also enabled me to consider the facilitation of focus group discussions by creating an environment where participants could speak freely. In addition, it allowed me to evaluate the proposed setting, the seating arrangements, and the presence of an observer who had experience in conducting focus groups. To recruit occupational therapy students to the pilot focus group, I asked the academic staff of the Department of Occupational Therapy to advertise the project to fourth year students. After advertising the project, eight students expressed an interest in taking
part in the pilot focus group. All students were sent an information sheet, the case examples, and a summary of Panyamee’s (2005) study one week before interview. For their convenience and safety, the focus group took place in a room at the Department of Occupational Therapy, Faculty of Associated Medical Sciences, Chiang Mai University approximately two weeks prior to the first focus group. I had anticipated that this would give adequate time to action feedback from the group and address any areas that would need improvement whilst still fresh in my memory.

The pilot focus group was structured to follow the same format as the actual research group. All students were welcomed and asked to complete a consent form. They were given background information regarding the study and the discussion followed guided questions as detailed in Appendix 4. At the end of the discussion the group were given an opportunity to provide comments regarding the questions, my style of approach, the environment, the seating arrangements, and any other aspects that in their opinion benefited or detracted from the group discussion. The main points of their comments concerned the clarity of the questions, the room temperature and length of time taken. Then, the observer provided feedback on the session. Changes to the research method included the sequence and rephrasing of the questions. Feedback from the group and the observer gave me confidence in my ability as a moderator and highlighted areas for improvement that could be acted upon prior to the main study.

5.4 The Main Study

When I conducted interviews, as I did not have assistance from a moderator, I normally arrived at the venue 30 minutes to 1 hour before the appointment time in order to prepare the room and check equipment. Participants in focus groups were
arranged so that participants who worked in the same workplace were separated from each other. This was derived from my experience from the first focus group where participants who came from the same workplace preferred to sit together. They sometimes talked to each other whilst others participants were discussing the independent living topic. I always sat in the position that enabled me to see all participants and allowed me to control a tape recorder. I sat next to participants for the individual interview, in order to avoid the feeling of confrontation which might make participants uncomfortable. When participants arrived, they were welcomed with refreshment and asked to complete the consent form. Participants were asked whether they knew each other. In cases where there was anyone that the other participants did not know, they were asked to introduce themselves to the group.

The aims of the independent living concept and the interview questions were written down on flip charts in order to allow the participants to relate to the aims of independent living concept and interview questions. At the beginning of interview, I introduced the focus group, the group rules, and my role as a moderator. From the literature, there are two points of view about the role of moderator in a focus group (Krueger and Casey 2000; Patton 2002). The moderator may take on an authoritarian role (Patton 2002) or a guiding and facilitating role, encouraging participants' interaction between themselves and with the moderator (Krueger and Casey 2000). This study aimed to explore opinions and understandings on independent living in Thai occupational therapists, to explore strategies for practice, and to identify a model of practice giving support to independent living. Therefore, the process of acquiring the data that enabled the research aims to be met was an inductive one, that needed to be supported by participants, facilitated by discussion within a comfortable, non-
threatening environment where participants could freely discuss their feelings, opinions and experiences. As an occupational therapist with experience in working with Thai disabled people seeking independent living and involving with academia, I shared my own experiences with participants, and also gave them current situations of independent living in Thailand in order to encourage them to discuss the issue.

In the first question used as an ‘ice breaker’, I asked them their opinions on the information on independent living and case examples provided. Providing them with information of independent living enabled them to talk about their opinions and understanding about the independent living concept and the case examples enabled them to recall their experiences about disabled people’s lives. Consequently, participants provided their experience regarding Thai disabled people’s lives. They also identified barriers preventing disabled people from achieving independence. This enabled participants to establish a context in which to discuss the following questions. For example, when participants talked about what support should be offered to disabled people in order to enable disabled people to have self-direction, they were asked to link their thoughts with the lives of disabled people and the barriers they had discussed previously. I took note of all important information they raised.

My first technique in facilitating discussion was asking a volunteer to start the discussion. If there was no one wanting to start the discussion, I then chose a participant to begin. Even though it was sometimes difficult to find someone to start the discussion, discussions normally went quite well. Although most participants in the focus groups knew each other, some participants were reticent to speak. Therefore, I encouraged them by asking them to begin from their experiences related to the
questions. Dominant participants were asked to give other participants an opportunity to share their opinions. For participants who talked together whilst other participants were speaking, gestures was used to indicate that they stop talking. Additional questions were used throughout interviews when vague information was given. I also summarised what they discussed before moving to the next question. This enabled them to check whether my understanding was correct. As this study used a phenomenological approach as a research framework, my professional background as well as additional questions and summarisation enabled me to explore and understand participants' experiences and opinions at a deeper level. I used the same encouragement of participants in focus groups when I did individual interviews.

In general, discussions were friendly and ran quite smoothly. They expressed their opinions and shared their experiences with the group as well as listening to each other. Sometimes they supported other participants' ideas and sometimes they suggested different ideas. Discussion sometimes occurred spontaneously. I facilitated some participants to speak and controlled dominant members. After each group had finished, participants were thanked. I summarised what they talked about, what would happen with the information they gave, and what would happen in the post group.

In summary, this chapter aimed to expand the theory of the research regarding the use of the research method, and the interview questions. It also gave details about what I did in the pilot focus group and the main study. In the next chapter, the results and discussion of the results will be presented.
Chapter 6

Understanding and Beliefs about Independent Living

Previously, the methodology of the study was described and expanded. From this chapter, analysis and discussion of the results of the study will be presented. The first part of this chapter is about the participants’ view of what independent living means to them. It also presents participants’ opinions about independence. In the second part, the participants’ viewpoints of these issues are discussed relating to the literature.

6.1 The Significance of Independent Living

When participants were asked what independent living meant to them, all participants agreed that the independent living concept was important for everyone not only disabled people. Participants provided its importance from both an ‘individual’ viewpoint’, and an ‘occupational therapist’s’ viewpoint’.

6.1.1 The Viewpoint as an Individual

In participants’ opinions, independence allowed them a positive feeling about themselves including ‘worth’, ‘no stress’, ‘pride’, ‘confidence’, and ‘enabling living’. Some participants said they would feel a sense of worthlessness and stress if they were incapable. A comment by a participant highlighted independence as a sense of worth with no stress:

*In my opinion, if ever we couldn’t live independently, having to depend on someone else, we would feel worthless. Going from being independent to dependence, we would feel anxious because we could not do things we used to do.*
Some participants reported a sense of pride when they could do things themselves. A comment by a participant from the Central part of Thailand concerned the sense of pride:

*For me, I feel proud when I can do things myself whatever they are easy or difficult. Anyway, if I can do difficult things, I would feel more confidence that enable me to do and try new things.*

In addition, independence was valued as a way of enabling living. A comment by a participant working in an academic area related to this issue:

*Independence lets us feel like a ‘normal’ [enabling] man. If an individual lacks freedom, he/she cannot make decisions him/herself, cannot determine his/her life, cannot initiate doing things on his/her own, it would look like that individual is ‘abnormal’ [he/she has something wrong].*

(Note: It must be remembered that ‘normal’ and ‘abnormal’ are not regarded as negative in Thai as would be the case in English; see Chapter 3)

In addition, some participants valued independent living from a disabled person’s perspective. Being independent for disabled people would ‘not be a burden on their families’, ‘be accepted by others’, and ‘be accepted as a model for other disabled people’. A comment by a participant working in the North valued independence as not being a burden on family:

*If I were disabled, I would try to do things myself. I don’t want to be a burden on my family. .... If my family members have to help me in doing things, they would have difficulty. It would be boring work.*

Another comment by a participant who worked in the North-East area reflected independence as acceptance:

*Apart from not being a burden on the family, another important point is I would be accepted by others as able to do things independently. Perhaps, I might be accepted as a model for other disabled people.*
6.1.2 The Viewpoint as an Occupational Therapist

Independent living was important to participants because they were involved with disabled people. They expressed their points of view from at least three positions - 'a goal of occupational therapy', 'a role', and 'feelings'.

Independence was valued as a goal of occupational therapy. A comment by a participant who worked in an academic area concerned this issue:

Independent living for disabled people is the ultimate goal for occupational therapists. What we provide for them is something enabling them to be independence.

A participant who had experience in working with a local self-help group in the North-East area seemed to have a good understanding of health professionals' roles in promoting independent living for disabled people. A comment related to the role:

According to the independent living concept, I think occupational therapists should take a supporting role. We cannot be a leader. We should be a helper or counsellor. .... Disabled people have to be in charge in every step. This might not be our direct job.

Participants reported both positive and negative feelings in response to the above-mentioned role. Some participants felt it was 'difficult' if they had to encourage disabled people to engage in independent living. A comment by a participant in an academic area reflected the feeling of difficulty:

It is hard to encourage clients to realise the benefits of independence. ... Clients sometimes are not receptive. They do not understand how their lives would be better if they showed self-reliance. They want their relatives to do things for them.

On the other hand, some participants reported positive feelings including 'pride', 'happiness', and a 'sense of professional pride'. A comment from an individual interview concerned the positive feelings regarding pride and happiness:
We are happy if disabled people can live independently. We are proud that we can support them.

Another comment by a participant from the North concerned the positive feeling regarding a sense of professional pride:

If disabled people can live independently in their communities, this would allow us to feel that we are really occupational therapists.

6.2 The Degree of Independence

In participants’ opinions, independence did not mean absolute freedom in all aspects of life even thought all of them agreed that the independent living concept was a useful concept. Participants thought that the degree of independence of an individual should be dynamic and subjective. Two comments by participants working in an academic area referred to the degree of independence:

An individual should have his/her own optimal level of independence. The level of independence should be dynamic depending on an individual’s contexts.

The degree of independence should be subjective depending on an individual’s feeling of satisfaction.

Some issues affecting the degree of independence were raised. This included ‘social connection’, ‘dependence among people’, ‘respect for other people and not against the law’. A comment by a participant from the North reflected the issues influencing the degree of independence were shown as follows:

We are a part of society. So, we cannot be a solo individual to have freedom. We should have a certain amount of freedom enough to not interfere with others and not to break laws.

It was supported by a comment by a participant working in the academic area:

It is difficult to be independent all of the time. An individual must have social interaction. We sometimes have to ask for help from other people. We sometimes cannot do what we want and when we want. We sometimes have to show consideration for other people’s feelings and depend on other people.
6.3 Discussion and Summary

This chapter presented what independent living meant to participants as individuals and as occupational therapists. They discussed this issue emphasising two aspects including 'the significance of independent living' and 'the degree of independence'.

6.3.1 The Significance of Independent Living

The results of the study indicated that all participants valued independence. They agreed that the independent living concept was good and useful. As individuals, participants reported positive feelings about living independently. However, behind the positive feelings reported, it appeared that they had interpreted independence as functional ability and self-autonomy. According to the independent living movement, the meaning of independence includes two essential elements: assuming responsibility for directing one's own life, and participating in community activities as an active member (Brisenden 1998; Cole 1979; Crewe 1979; Oliver 1996). The participants' opinions regarding self-autonomy had the same meaning as a simple level of the philosophy of independent living with respect to being in charge of one's own life (Crewe 1979; Morris 1993). But independence that referred to functional ability seemed less than full active membership of the community.

According to the independent living concept assumed by the social model of disability, disability is constructed as a product of the intersection of the individual and the socioecological context (Hammell 2006; Pledger 2003). However, a major thrust of this construct is that external factors have the potential to contribute to and shape the disability experience (Hammell 2006; Pledger 2003). Moreover, independence is defined as an ability to be in control of and make decisions about
one's life rather than doing things without help (Reindal 1999). Disabled people who could help themselves in doing things might or might not be able to participate actively in the community. On the other hand, disabled people who were dependent for daily tasks might be active members of society. Therefore, if the meaning of independent living for the participants is confined to functional ability, that would not be consistent with the meaning of independent living at the visionary level as defined by disabled people.

However, although the Thai occupational therapists defined independence as a functional ability, it was remarked that rehabilitation professionals tended to define independence as the ability to conduct self-care activities without physical assistance rather than self-autonomy (Reindal 1999). Hammell (2006) stated that medical and rehabilitation services under the medical model of disability aimed to provide treatment in order to enable individuals to overcome their functional deficits and appear in a manner that is as near to normal as possible. Therefore, from the apparent inconsistency in the participants' understandings might be influenced by the medical model of disability. From independent living's perspective, "Independent living should be viewed not merely as a social movement, but also as a state of mind that should become deeply rooted in our basic understanding of disability issues" (DeJong [no date]). Therefore, it is necessary to promote more understanding about the independent living concept in Thai occupational therapists.

Participants also reported the importance of independent living to them as occupational therapists. They reported that independent living for disabled people was a goal of occupational therapy. Participants' report was concurred with an
international occupational therapists’ viewpoint that the ultimate goal of occupational therapy service was to enable people to participate in the activities of everyday life (World Federation of Occupational Therapists [no date]). It was also in line with the work of Bowen et al. (1993) regarding the role of occupational therapists in independent living programmes and Townsend (1993)’s work concerning the role of occupational therapists in promoting or at least taking into account social justice as a concept.

Even though participants valued independent living for disabled people as a goal of occupational therapy, they did not view themselves as leaders who could realise independent living for disabled people. Rather than taking a principal role in decisions about services provided to disabled people, participants viewed themselves as taking a supportive role when disabled people needed to live independently. Participants in the study reported that they tried to encourage disabled people to take responsibility on managing their own lives. This was supported by Oliver (1999) who stated that to enable disabled people to achieve the autonomy and control that they wanted in their lives, professionals should change their roles in order to work with disabled people. Such a collaborative approach between healthcare professionals and disabled people is also promoted by Bowen et al (1993) and Passmore et al. (2008).

Even though participants in this study intended to be supportive for disabled people seeking to live independently, it was necessary to consider how long support should be provided. DeJong (1979) remarked that a constant medical presence in the lives of disabled people would induce dependency. Although disabled people’s management skill might not be well developed because of lack of practice opportunities, disabled
people should be allowed to function as autonomously as possible (DeJong 1979). As participants reported the goal and their role related to independent living, the study indicated how independent living concerning autonomy and participation had been integrated with values and responsibility shared by the participants.

As occupational therapists, participants also reported their positive and negative feelings in response to the abovementioned goal and role. Having positive feelings to the goal and role would encourage participants’ enthusiasm in providing support to disabled people to engage in independent living. On the other hand, feeling that there were difficulties in encouraging Thai disabled people to leave dependence and become independent might be a barrier to promoting independent living for disabled people. However, this might not have much effect since all participants as individuals reported gaining positive feelings for themselves when they were independent.

6.3.2 The Degree of Independence

Even though all participants valued independent living, they reported that the degree of independence should be subjective and dynamic depending on an individual’s context. From their opinions, ‘social connection’, ‘dependence among people’, ‘respect other people and not against law’ affected the degree of independence. The result of social connection and dependence were similar to those of Panyamee’s (2005) study in 13 Thai people with acquired physical impairments. She found that participants were prevented from taking full control of their lives and participating in the community because of their feeling of dependence. As her participants needed help from their family members, independently living was felt to be an inconvenience to others. This study indicated that the participants were empathetic by demonstrating
similar thoughts to those of Thai disabled people. Therefore, it might be assumed that they had no barriers to promoting independent living.

The result of this study and Panyamee’s study highlighted the characteristics of collectivism influencing on the way of life of Thai people. Collectivism stresses human interdependence and the importance of a collective rather than the importance of separate individuals (Triandis 1995). This contradicts with individualism in Western culture that stresses the autonomous self (Triandis 1995). Individualists believe that their behaviours are reliant on internal attributes (Triandis 1995). The self is defined independent of the group; a person should do what is enjoyable and required by contact with others (Triandis 1995). However, the notion of individualism and independence perceived in Western culture is argued. It is observed that humans are all dependent to a greater or lesser degree on others (Walmsley 1993). This situation is called interdependence which is claimed to be an essential feature of the human condition (Reindal 1999). It was likely that the community perspective of independent living suggested by Woodill (2006) focusing on partnerships and relationship among people might be suitable for disabled people in Thailand. Even though the similarities and disparities between Eastern and Western culture are controversial, promoting independent living originated from an individualistic culture and the fact that Thai disabled people belong to a collectivistic culture needs to be taken into account.

Participants thought that individuals should be entitled to freedom without interference from others and against law. Participants’ opinion supported the notion of human rights that was defined as “a set of principles based on social justice; a
standard by which the conditions and opportunities of human life can be evaluated” (Armstrong and Barton 1999; p 211). Everyone is entitled to two fundamental human rights including the right to wellbeing and the right to freedom, the latter being that everyone has the right to do as his/her wish without interference from others and the state (Witkin 1999). However, Hammell (2006) stated that the only limitation to an individual’s action is that other people’s rights to freedom or to wellbeing has not to be threatened or violated. The study indicated that the participants could grasp the message of Western society regarding human rights even though some of their opinions showed the dominance of the collectivistic culture of Eastern society. Again, it seems that their thoughts regarding respecting other people is not a barrier to providing support for independent living.

In summary, this study showed that all participants realised the importance of independent living. However, some participants had misunderstandings about the meaning of independence promoted by the independent living movement. Rather than defining independence as physical ability, the notion of control should be promoted in Thai occupational therapists. Even though having personal difficulties in supporting and changing the attitudes of Thai disabled people from dependence to independence, their positive feelings from the experience might be able to abate their negative feelings. Although participants seemed to understand the degree of independence based on the knowledge of human rights, the influence of collectivism on participants’ opinion about the degree of independence was found. It is necessary and important to consider cultural differences when implementing the independent living concept in Thailand.
Chapter 7

The Feasibility of Independent Living in Thailand

The previous chapter expressed the occupational therapist participants’ opinions on the significance of independent living and the degree of independence. This chapter presents and discusses their views of the possibility of independent living for Thai disabled people. Factors influencing the possibility of independent living are also identified and discussed. Similar to the previous chapter, Chapter 7 is arranged in two parts. Whilst the first part shows the views of the participants on the issues, the second part will present the discussion relating to the literature.

7.1 Feasibility of Independent Living

Participants had strong views on the feasibility of independent living for disabled people in Thailand. Some participants thought that it was possible for Thai disabled people to be in charge of their lives and be active members of society whilst some participants expressed the opposite opinion. Those who thought that independent living for disabled people was possible reasoned that in their opinion that they had noticed changes in family structure within Thailand and the rising level of education of people in general. A comment by a participant from the Central area concerned this issue:

*From my experience over 10 years, I have noticed the tendency in changes. People have higher education. We can see some people start accepting disabled people. Some disabled people can live independently and contribute to society. Another thing is a change in our way of living. Family structure has tended to change from an extended family to a nuclear family. This would force disabled people to live on their own.*
Some participants confirmed that currently a few disabled people were living independently even though their independence might be different from independent living in Western culture. One participant who had experience working with a local self-help group in the North-East area shared her experience about a disabled person receiving informal care from his family:

I used to see a client. He received help from his family in daily tasks but he was quite independent. He could decide about his life and business. He didn’t hire a personal assistant as disabled people in Western culture.

In addition, to confirm the possibility of independent living in Thailand, some disabled peoples’ organisations were also given as an example. For example, a participant from the Central part of Thailand talked about a disability organisation that was advocating the rights for disabled people in a particular province.

On the other hand, some participants reported that it was difficult for Thai disabled people to live independently. They thought that it would take a long time for disabled people to change from dependence to independence. A comment by a participant working in an academic area concerned this issue:

I think it would take a long time. This is because disabled people are not ready for living independently. Currently, their basic needs [finance, accessibility] are not fulfilled yet. Their attitudes towards themselves are problematic as well. So, it would take time for disabled people to fulfil their basic needs before going up to higher steps [rights, consumerism] as stated in the independent living concept.

7.2 Factors Influencing Independent Living

Even though participants had two different points of views about the feasibility of independent living for disabled people in Thailand, all participants concurred about factors influencing independent living for Thai disabled people. They felt that to drive independent living to be a reality, cooperation from multiple levels of society was
required. This included 'disabled people', 'family', 'people in the community', and 'the Thai government'. Additionally, they reported that some other support including 'finance' and 'physical environment' were also necessary. These factors are shown in detail as follows.

7.2.1 Disabled People

Disabled people themselves were reported as having an influence on the possibility of independent living in Thailand. Participants discussed this factor referring to two aspects: 'affective' and 'physical ability'.

7.2.1.1 Affective

Concerning the affective aspect, negative attitudes of disabled people towards themselves were discussed extensively. It was felt that their negative attitudes would prevent them from engaging in independent living. Such negative attitudes toward themselves included a rejection of disability, and a feeling of dependence and incapability. These then resulted in them seeking other curative methods, denying themselves recognition as a disabled person, feeling worthless, and losing self-confidence. A comment by a participant working in the Central area concerned this issue:

Most disabled people hope to be 'a normal' [get well] and believe that they would be able to do things as the same. They think that they are temporarily incapable. They need help from their family members and others. ... They refuse to be registered as a person with disability. They do not see the importance of how to do things themselves. They believe people who advise them about Thai traditional medicine.

(Note: It must be remembered that 'a normal' is not regarded as negative in Thai as it would be in English; see Chapter 3)
Another comment by another participant concerned this issue:

Some disabled people feel incapable and worthless. This results in them not daring to go outside.

The benefit of will-power was highlighted as an important resource in enabling disabled people to achieve independent living. A comment by a participant working in an academic area concerned the benefit of will-power:

Disabled people think that they are sick and hope to be 'normal' [get well]. They keep waiting for two or three years. Then, they realise that it is impossible. They fail. Some disabled people who have strength can get back to live independently, but some disabled people cannot. Rather than getting back and trying to live independently, they think that it's not so long till death. So, they think that they do not need to do anything.

Some participants also discussed personality. They reported that disabled people who had a passive nature would not be able to attain independent living particularly as it requires self-advocacy and being an active consumer. A comment by a participant from the Central part pointed to the issue of personality:

Some disabled people are passive. They think that health professionals should know the best about how to cure them. So, they leave it to health professionals to decide what health services they need. They do not dare to ask for information.

7.2.1.2 Physical Ability

Even though participants did not emphasise the physical aspect of being disabled as much as the affective aspect, they agreed that physical ability also had an impact on disabled people in attaining independent living. A comment by a participant working in an academic area highlighted the impact of physical ability:

People who have more impairment would have less chance of achieving independent living. They need much more support in order to live independently.
7.2.2 Family

Family factors were reported as being important with both positive and negative impacts on the possibility of disabled people attaining independent living. Participants discussed two aspects of family life: ‘family attitudes’ and ‘support provided’.

7.2.2.1 Family Attitudes

Participants experienced three types of attitude towards disabled people in families. These were ‘over-protectiveness’, ‘acceptance’, and ‘rejection’. Participants thought that family attitudes were dynamic and could be changed from time to time based on interactions between disabled people and their family members. One participant in a re-convened academic group expressed his opinion:

There is no study to account explicitly for family responses to disability. Anyway, from my experience, I found many kinds of family attitudes towards disabled people. In the first stage, disabled people might not be able to accept their disabilities. Family members might protect them. Help them doing everything. Not so long ago, when family resources ran out, family members then might reject them if they didn’t adjust themselves to live with disability. If disabled people could adapt their lives to be with disability, running out of family resource might not occur. It is like a process. It might start with protection and be followed by rejection one year later. Or, it might begin with rejection and then acceptance when disabled people and their family members could adjust themselves to life with disability.

7.2.2.2 Support Provided

As mentioned in Chapter 2, caring for disabled people in Thailand occurred in the family context. A comment by a participant from the North highlighted this notion:

Disabled people in an extended family were not abandoned. Their relatives who lived in the same area would come to look after them when the primary carers were not available.

It was also felt that family members did not have a good understanding about disability. Culture was also reported as the reason why family members provided
support to disabled people whether disabled people wanted it or not. The following is a comment by a participant working in the North about culture:

It is a Thai value that family members do not want disabled people to have difficulty in doing things. They think that disabled people would be able to do things themselves when disabled people recover to be normal.

When participants talked about how families provided help to disabled people, three levels of family support were discussed including ‘doing everything for disabled people’, ‘providing support appropriately’, and ‘providing less support’. Doing everything for disabled people was reported to limit the opportunity for disabled people to show their capabilities. A comment by a participant from an individual interview highlighted this issue:

Some disabled people want to do things independently. However, their family members do not allow them to do so. Helping disabled people in everything would make disabled people dependent all the time.

Some participants acknowledged the benefit of appropriate family support in enabling disabled people to attain independent living. A comment by a participant from the North stated appropriate support from family:

If family members had a good understanding about disability and provided appropriate support, this would enable disabled people to live independently. Disabled people would feel confident that they could do things themselves. They would feel that they are not a burden on anyone in society.

Some participants experienced family members who provided less support for disabled people. Consequently, disabled people did not receive good care. A comment by a participant working in the Central part related to providing less support:

I sometimes taught family members how to provide help for disabled people. However, some disabled people said that their family members have never done whatever I taught. They were so sad that their family members did not provide them with a good care.
Work was reported as a cause of family members providing less support for disabled people. A comment by a participant confirmed this:

*Family members sometimes want to take disabled people out into the community. Unfortunately, they have no available time. They have to work.*

7.2.3 People in the Community

People in the community were reported as having a supporting role for disabled people in achieving independent living. A comment by a participant highlighted the positive impact of people in community:

*Being accepted by people in the community would make disabled people feel much more courageous to do things.*

However, participants experienced various attitudes. Some participants experienced positive attitudes of people towards disabled people particularly in small communities. One participant working in an academic area described a positive attitude of people in the community:

*From my experience, I found that people in the small community [rural] normally provided opportunities for disabled people. They learnt to adjust themselves to be with disability easier than people in the city. May be, they had sympathy for each other. They supported disabled people in whatever they could do in order to enable disabled people to get back their lives.*

On the other hand, negative attitudes of people in the community towards disabled people were reported. These negative attitudes included ‘pity’, ‘fear’, ‘stranger’, and ‘segregation’. In the views of participants, these negative attitudes were the result of a lack an understanding about disability, and also prevented disabled people from enjoying their lives in the community. Four comments from four participants can be quoted as examples. The first comment highlighted the negative attitude regarding pity:
We found that people in the community did not absolutely accept disabled people. People viewed disabled people as people to be pitied who need help and charity. They also viewed disabled persons as people who had difficulty and limitation. Pity was an un-equal form of relationship.

The second comment concerned the feeling of fear:

*People do not understand. They fear and do not want to get close to disabled people.*

The next comment related to being stared at like a stranger:

*Some disabled people do not want to go into the community. Why? They feel embarrassed. People stare at them as a stranger.*

The last comment concerned segregation:

*People in the community think that disabled people should not be and do the same thing with other people. They often ask that why disabled people have to marry or have children?*

7.2.4 Finance

Finance was reported as having an influence on the feasibility of independent living for disabled people. Participants discussed this issue in three ways which included the ‘importance of financial security’, ‘indirect impact of financial restriction’, and ‘financial support from the government’.

7.2.4.1 Importance of Financial Security

In the view of participants and based on their experience, most disabled people were confronted with financial restrictions. Consequently, disabled people were limited in their opportunities to live independently. Having financial security would increase opportunities for disabled people in engaging in independent living. A comment by a participant working in the North-East region concerned this issue:
Disabled people who are rich would have more chance than poor disabled people to go into the community and live independently”.

Having financial support was reported as enabling disabled people to afford the necessary things to live independently. A comment by a participant working in the North concerned this issue:

Finance was important for disabled people because it enable them to modify their environment to suit their physical conditions and have any necessary equipment”.

7.2.4.2 Indirect Impact of Financial Restriction

Financial restriction was also reported as having an indirect impact on relationships and self-autonomy. A comment by a participant working in the Central region concerned this issue:

From another point of view, after acquired injury, disabled persons might have to change their role from a person who earned money for the family to a person who depended on their family regarding finance. Their family members needed to earn money instead of them. This would impact on relationships between disabled people and their family members. We found that some disabled people were divorced. Also, some disabled people let time pass from day to day. They accepted whatever their family members provided them. They wouldn’t dare express what they wanted.

7.2.4.3 Financial Support from the Government

Participants mentioned that financial support from the Thai government would relieve financial constraints for disabled people. However, some participants reported that the current government financial support was only a small amount of money and was limited. A comment by a participant provides evidence of this support:

The Thai government grants 500 Bahts [approximately 10 Pounds] per month to a disabled person. 500 Bahts is not enough. It cannot do anything at present. Also, this support is not for all registered disabled people although not all disabled people want to be registered. It depends on how much each province receives as a budget from the government.
7.2.5 Physical Environment

The physical environment was discussed as having an impact on disabled people to live independently. Participants reported that physical barriers prevented disabled people enjoying their lives in the community. From their experience, physical barriers were found everywhere, not only in rural areas, and existed due to a lack of awareness about the access needs of disabled people in the community. A comment by a participant working in the North-East region concerned physical barriers in the community:

*I used to assess the physical environment as to whether it allowed disabled people to access the community. I found that disabled people could not access many places such as post offices, parks, banks, a city hall, hospitals, markets, and superstores. Some places were too crowded. Footpaths were not appropriate for disabled people to walk or use wheelchairs. There was no ramp provided for disabled people to access buildings. Even though some places provided a ramp at the entrance, disabled people could not access the ramp because a car was parked in front of the ramp.*

7.2.6 The Thai Government

The government was another factor which influenced the possibility of independent living for disabled people. One question was raised from a participant working within an academic area as to whether promoting disabled people to live independently was conducted in line with the independent living concept:

*The independent living concept focuses on encouraging disabled people to be an active member of society rather than living in institutions. However, in Thailand, we push disabled people to live in institutions for training in whatever the institutions provide. After being in the institutions for a while, we hope that these disabled people should be able to live independently. Rather than implementing the independent living concept through disabled people, we rely on developing them through institutional processes. So, I wonder whether rehabilitation in Thailand is on the right track for independent living.*
Some examples were given to support the question raised. One example was given by a participant from the North who had working experience of more than 10 years concerned developing vocations for disabled people:

Even though disabled people can develop vocational skills at vocational centres provided, they do not know what to do when they go back to the community. There is no work available for them. This makes them desperate.

Participants discussed the role of the Thai government regarding disability in three areas including 'the act and regulations', and 'policy and strategies', and their overall 'ineffectiveness'.

7.2.6.1 The Act and Regulations

At the time of conducting fieldwork, participants thought that the Rehabilitation of Disabled Persons Act A.D. 1991 (B.E. 2534), the chief act in Thailand, comprised broad points of view without practical guideline. A comment by a participant who had work experience in providing services for disabled people in the North for 18 years and having concerned this issue of the Act and regulations:

The Act is quite broad. It mentions education, medical, work, and...for disabled people. It focuses on the equality between disabled people and able-bodied people. I think it does not have clear detail for practice.

Some participants thought that the Act and regulations were not abreast of times particularly in recruiting money to the Fund for Rehabilitation of Disabled Persons and providing work opportunities for disabled people. A revision of the Act was suggested in order to enforce all companies to provide work opportunities for disabled people. A comment by a participant working in an academic area concerned the revision of the Act:

One part of the Rehabilitation of Disabled Persons Act in B.E. 2534 mentioned about the Fund for Rehabilitation of Disabled Persons. However,
the Thai government failed to allocate a budget when establishing the Act. Therefore, the Thai government tried to recruit money into the Fund by offering an alternative option for employers or private companies who did not want to employ disabled people to donate money to the Fund. At present, the Fund should have some money. Disabled people also need to work. Hence, the Act should be revised in order to increase opportunities for disabled people to work. All companies should be enforced to employ disabled people rather than make a donation.

Some participants discussed the lack of monitoring and penalty provisions for organisations that did not confirm to the Act and regulations. A comment by a participant working in the Central region concerned the lack of a monitoring system in providing work opportunity for disabled people:

Do you know how many companies employ disabled people? In fact, neglect by companies is the norm. Nobody takes responsibility to monitor these companies.

Another comment by a participant stated the lack of monitoring and penalty system in providing accessibility for disabled people:

It is difficult. Although accessibility for disabled people to enable them to access buildings was required in the Act and regulations, we found that disabled people were not able to access some places when they went into the community. How did that occur?

7.2.6.2 Policy and Strategies

In addition to the Act and regulations, the second National Plan of Quality of Life Development A.D. 2002-2006 was discussed. As health professionals who were involved with disabled people, participants reported that they were informed about the National Plan. However, they were not informed about its strategies. A comment by a participant working in the Central area concerned this issue of policy and strategies:

I knew that the Thai government had a policy to increase quality of life of disabled people but I did not know in detail what I need to do.
In addition, participants reported that there were no outcomes from the second National Plan of Quality of life Development. It was reckoned that this policy might not be considered a high priority. A comment by a participant involved within an academic area noted the lack of outcomes for the Plan:

This Plan has nearly come to an end but nothing happens. The Thai government has made a start with revising the Act. Anyway, I have not seen any outcome yet.

7.2.6.3 Ineffectiveness

Participants thought that the government's operation regarding quality of life development for disabled people was ineffective. The lengthy efforts of the Thai government in this issue was discussed broadly in three ways including 'complicated procedure', 'lack of continuity', and 'lack of cooperation'.

The complicated procedure of some projects was reported to prevent disabled people from accessing services. Offering disabled people to obtain a loan from the Fund for Rehabilitation of Disabled Persons for vocational purposes was given by a participant working in an academic area as an example:

Disabled people who wish to raise a loan [maximum 20,000 Bahts or approximately 400 Pounds] from the Fund need to do a paper work. We have to accept that most disabled people normally have low education. It is impossible for them to develop a project and prepare plenty of supporting documents. It looks like when we want to raise a loan from banks. The Thai government should change this procedure to be simpler than the current procedure.

Another example was given by a participant from the Central area pertaining to the complicated procedure in providing equipment for disabled people:

When disabled people require assistive devices for free, hospitals need to make contact and request those devices from a rehabilitation centre. The centre receives a grant from the government. It normally buys devices using standard specifications. This should be decentralised because it is difficult for
disabled people to access services. The centre should distribute its budget to provincial hospitals in order to enable hospitals to order what disabled people want. Besides, using standard specifications is not flexible. As we know that disabled peoples' needs vary, disabled people are constrained in use of the appropriate devices because hospitals cannot manage equipment themselves.

Lack of continuity in the government's projects was also reported as a barrier for disabled people to achieve independent living. Participants thought that lack of continuity resulted in the government’s projects making slow progress. A comment by a participant having work experience more than 15 years concerned this issue:

*It is fashionable. When something booms, the government would pay attention to it and generate activities for responding to that issue. Not so long, the government’s intention is away. Nothing happen. The government's intention is periodic. Nobody is a coordinator who takes responsibility on proceeding projects. Currently, the government wants us to survey disabled people in the community and register them.*

In addition, lack of cooperation between government organisations was highlighted as a cause of ineffectiveness of the government’s operation relating to disabled people. A comment by a participant working in an academic area focused on this issue:

*From what I see, government organisations relating to disabled people are in several ministries. Each organisation deals only its work. They do not cooperate to each other in order to response disabled people’s needs.*

For example, some participants reported a lack of cooperation between the National Health Security Office and hospitals controlled by the Ministry of Public Health. The lack of cooperation was reported to have a negative impact on disabled people as consumers who should be able to choose health service providers. A comment by a participant working in the North reflected this issue:

*According to the new policy of the National Health Security Office, in case of necessity, registered disabled people who hold a gold card can receive free health services in any hospital. However, it does not happen like that. When disabled people go to hospitals that are not specified on the gold card, they are turned away. They are asked to bring a referral letter from a hospital*
where they normally receive health services. Otherwise, they need to pay for health services.

7.3 Discussion and Summary

This chapter presented participants' opinions on the feasibility of independent living for disabled people in Thailand. It also expressed their views relating to factors influencing independent living. These issues are discussed below.

7.3.1 Feasibility of Independent Living

Participants had two opposite ways of thinking regarding the issue of the feasibility of independent living for disabled people in Thailand. Some participants thought that independent living for disabled people in Thailand was possible because of the tendency of changes in family structure and the improved level of education of people. As mentioned in Chapter 3, the family structure in Thailand has changed from an extended family to a nuclear family (Ministry of Public Health 2005). Family members need to work outside home to earn money. Consequently, being left alone at home has encouraged disabled people to be more independent and self-reliant. The literacy rate among the Thai population aged 15 and over has risen from 78.6% in 1970 to 95.7% in 2001 (Ministry of Public Health 2005). It is also estimated that it will be as high as 97% in 2010 (Ministry of Public Health 2005). Having a higher education level would enable people in the community to have wider visions. Consequently, people in the community may be able to accept disabled people more easily. Disabled people also have had more opportunities to become educated (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991). This has enabled disabled people themselves to become more self-confident and contribute more to society. Therefore, it is possible that the
changes in family structure and education level of people could be the mechanism that will help make independent living for disabled people a reality.

On the other hand, some participants thought that it was difficult and it required a lengthy period of time for disabled people to engage in independent living. They thought that Thai disabled people themselves were not ready for independent living. In addition, they reported that support systems from the government were not good enough for enabling disabled people to be independent. These factors will be discussed later.

7.3.2 Factors Influencing Independent Living

Even though there were two different points of view regarding the feasibility of independent living for disabled people in Thailand, all participants agreed that there were some factors influencing the possibility of independent living which included 'disabled people', 'family', 'people in the community', 'the Thai government', 'finance', and 'physical environment'. Except for the Thai government, the rest of the factors reported by participants in the study were similar to factors influencing independent living in Panyamee's (2005) study of 13 people with acquired physical impairment.

7.3.2.1 Disabled People

The affective component of attitudes of disabled people themselves was reported to impact on the feasibility of independent living. Participants thought that some disabled people had negative attitudes towards themselves and their disability. Disabled people tended not to accept their disability and hoped to get well and return
to their pre-disability bodies. This indicated that disabled people lacked an understanding about disability. Similar to Panyamee’s (2005) study, the results showed that some disabled people felt a loss of competence and lacked an understanding about their disabilities and capabilities. From the literature mentioned in Chapter 3, it is a cultural belief according to Buddhist thought that disability is viewed as a product of sin and disabled people are viewed as people to be pitied (Viboolpholprasert et al. 1997). These beliefs seem to prevent disabled people from achieving ‘equality of esteem’ or motivation to overcome disability and handicap (Miles 1995). According to Thorén-Johnsson and Möller (1999), the conception of one’s capacities is reliant on an individual having a basic knowledge of his/her own body, abilities and limitations. From an independent living perspective, disabled people require a clear understanding of their capacities and their potential for involvement in life’s activities in order to develop appropriate expectations and the confidence to explore their potential. Therefore, a positive attitude towards disability and a good understanding about disability in Thai disabled people are required to promote independent living in Thailand.

In addition, participants reported that passive behaviour could be a barrier for Thai disabled people to be active consumers which is promoted by the independent living concept. One example given was the issue of receiving health services and holding physicians in such high regard that they were entrusted to take control of decisions on the health services provided. Komin (1990) conducted large scale research on the Thai value system. She identified nine clusters of values which could be arranged in order of importance for the respondents in her samples. One cluster concerned smooth, kind, pleasant, interpersonal interactions with an absence of conflict. This cluster was
valued third in importance. The cluster to which achievement belonged and being ambitious and hardworking to attain one's goals was ranked by respondents as the least important. This was unlike Western cultures whose highest ranking values tended to focus on self-actualisation, ambition and achievement (Komin 1990; Loveland 1999). The independent living concept, as generated in Western culture, requires disabled people to be a self-assertive in order to take full control of their lives. Therefore, it may be difficult for disabled people who have a typical Thai value system to engage in independent living. Even though characterising a national culture does not mean that everyone in the culture has all the characteristics arranged in the same order of importance, Thai value systems have to be noted when promoting independent living for disabled people in Thailand.

In contrast to passivity, participants in the study reported that will-power enabled disabled people to be in charge of their lives. This is similar to the findings of Panyamee's (2005) study where disabled people with self-knowledge, self-confidence, determination, and motivation felt able to make decisions, take control over their lives, participate in the community and exert their rights. Whilst self-knowledge resulted in her participants being able to identify their needs and feel confident about what they wanted to do, their determination, self-motivation, and courage also enabled them to overcome the inevitable barriers they encountered. Inner resources such as positive self-esteem, self-confidence, self-control, self-motivation, persistence, and enthusiasm were valued as important as they enabled disabled people to obtain high levels of control in their lives (West et al. 1995). In Komin (1990)'s study of clusters of values, the cluster ranked highest in importance was the one
which included self-esteem and self-confidence. From an independent living perspective, such personal qualities need to be fostered.

Participants reported that the degree of physical ability had an impact on the possibility for disabled people to attain independent living. They thought that people with severe impairments would need more support than people with minor impairments. However, they did not value physical ability as high as the affective aspect. This concurred with the opinion of Brisenden (1998), an early pioneer of independent living in the UK, who stated that the degree of disability did not determine the amount of independence achieved. The most important factor for independence was the amount of control they had over their everyday routine (Brisenden 1998).

7.3.2.2 Family
Family relationships were regarded as an important factor influencing the feasibility of independent living. Participants reported that family attitudes towards disabled people varied from rejection, acceptance to over-protectiveness. These attitudes were reported to be dynamic within the family unit. This was similar to the study by Turner (1996) about the levels and determinants of family support and family conflict in people with physical impairments. She found that family support and conflict tended to change depending on various factors across the life-span.

Participants also reported on the levels of support from family which included doing everything for disabled people, providing support appropriately, and providing less support. Whilst over-protectiveness and doing everything for disabled people limited
opportunities for disabled people to take control of their lives, rejection and providing less support resulted in disabled people not receiving good care. These situations indicated that their family members did not have a good understanding about disability and the independent living concept. In contrast, acceptance and providing appropriate support were acknowledged by the participants to enable disabled people to live independently. The result of the study concurred with Thai disabled people’s reports in Panyamee’s (2005) study. Other studies (Morningstar et al. 1995; Murphy et al. 2000; Song 2005) have reported the negative and positive impacts of family relationships on independent living for disabled people in both Eastern and Western countries.

The results of this study supported the notion that caring for disabled people in Thailand was in the family context (Oka 1988; Viboolpholprasert et al. 1997). It is a cultural norm based on Buddhist thought that helping disabled people will bring good fortune or karma and also allows non-disabled people to increase their social reputation (Naemiratch and Manderson 2009; Triandis 1995; Viboolpholprasert et al. 1997). Therefore, family members and relatives prefer to provide assistance to disabled people rather than support their independence. As the study indicated the possibility of Thai disabled people live more independently with appropriate support from family, implementing independent living concepts within the Thai community needs to show respect for the cultural beliefs which they hold dear whilst still ensuring the rights of vulnerable people within the community are being respected.

However, the independent living model generated from Western culture proposes that reliance on family support has a negative impact on both the carer and the person
receiving care (Morris 1997). Rather than receiving informal care from their families, the independent living concept adopted in Western and Eastern countries encourages disabled people to use personal assistants (Batavia 1998; Wang 2007; Yamaki and Yamazaki 2004). Therefore, adopting the concept of an independent living approach in Thailand may have to be modified to suit the Thai culture. Although informal care in the family may be acceptable, it is necessary to provide disabled people and their families with the concepts underpinning the independent living model that encourages disabled people to use personal assistants rather than a reliance on family. Besides, independence, according to Morris (1997), is about having control over how help is provided, it is necessary to support them in order to access and use personal assistant services if they are to develop freedom from having to rely on their families.

7.3.2.3 People in the Community

In addition to disabled people and family, people in the community were reported to have an influence on the feasibility of independent living for disabled people in Thailand. Participants acknowledged that being accepted by people in the community would provide disabled people with equal opportunities to exert their rights. Participants also reported attitudes of people in the community towards disabled people varied from positive attitudes to various negative attitudes. This was in line with the study of Naemiratch, and Manderson (2009) and Panyamee (2005). As reviewed in Chapter 3, attitudinal barriers prevented disabled people in Asia including Thailand from living independently in the community (Komardjaja 2001). In Thailand, disabled people are viewed as people to be pitied who should receive help in all aspects of life. This results in other people in the community viewing disabled people as incapable. Thus, this attitude prevents disabled people from enjoying their
lives and take a productive role in the community (Boonyarattanasoontorn et al. 2009; Hammell 2006; Oka 1988).

Negative attitudes of people in the community towards disabled people were also examined in Western and Eastern countries (David and Jansen 1999; Mcmillan and Soderberg 2002; Nagata 2008; Quigley 1995; Stephens and Yoshida 1999; Tighe 2001) However, when attitudes of Western and Asian people towards disabled people were compared in a study by Chen et al., American students were found to have a more positive attitude towards disabled people than Taiwanese and Singaporean students (Chen et al. 2002). The evidence of negative attitudes of people in the community indicated that some people in the community lacked an understanding of disability. It is stated that negative attitudes of people in the community are the greatest barriers to community living for disabled people (Peat 1997b). From an independent living perspective, it is necessary to develop an understanding about disability in people in the community in order to promote social inclusion for disabled people.

7.3.2.4 Finance

Finance was also reported to have an impact on the possibility of independent living for disabled people in Thailand. Participants reported that having financial support provided disabled people with opportunities to take control over decisions and their lives whilst financial restriction had negative impacts to self-autonomy and family relationships. Similar to Panyamee’s (2005) study, finance was found to have both positive and negative impacts on independent living for disabled people. West et al. (1995) noted that the availability of financial resources was often cited as a factor in
obtaining control over decisions, whilst lack of financial resources was often cited as an inhibiting factor for gaining control. Without financial resources, disabled people were not able to choose their preferred options for equipment, assistance or support.

Even though having financial support from the Thai government was reported, participants felt the amount of financial support was not enough. This was congruent with the work of Sungrugsaa et al. (2008). Whilst the average monthly income in 2001 was 4,061.67 Bahts with average monthly expenses of 3,341.67 Bahts (National Statistical Office [no date]), registered disabled people, who were not employed, currently receive financial support from the government of 500 Bahts per month (Bureau of the Empowerment for Persons with Disabilities 2005a; Ministry of Foreign Affair 2010). In addition, participants reported that financial support was not provided for all registered disabled people. According to the Rehabilitation of Disabled Persons Act (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991), the number of disabled people who receive financial support depends on the annual amount from the government budget. As there is an association between disability and poverty in Thailand (Patibatsorakich 2002) and financial support from the government is not enough and limited, this raises a concern that disabled people might continue to be limited in opportunities to attain independent living. Therefore, it is necessary to address financial restrictions in order to enable them to have an opportunity to be in charge of their lives and participate actively in the community.
7.3.2.5 Physical Environment

Physical environment was reported to be another factor that influenced the feasibility of independent living in Thailand. Participants reported that physical barriers prevented disabled people from enjoying their lives in the community. Barriers in the physical environment have been frequently cited as one of the most significant limitation (Economic and Social Commission for Asia and the Pacific 2003). Physical barriers were reported to be found everywhere both in disabled people’s dwellings and in the community. This was also evidenced in Panyamee’s (2005) study and supported by a survey undertaken by Kovindha (2000) who found that most public buildings, streets, and facilities such as telephones, toilets, and car parks did not allow access for disabled people. If these physical barriers are not addressed, disabled people will continue to be socially isolated and excluded from all spheres of social life.

Poor transportation and inaccessible facilities have also been reported in many other countries such as the Netherlands (Pluym et al. 1997), UK (Walker 1995) and the USA (Froehlich et al. 2002). The level of accessibility in countries varies depending on how long they have been aware of the issue, how systematic they have been in addressing the problem and the financial resources that have been available to address the issue. However, it is disturbing that despite having the ADA passed more than a decade ago (Froehlich et al. 2002), accessibility issues are still evident in rural areas of the USA (Wehman et al. 1999). Similarly, even though there have been several attempts to produce UK legislation which was intended to address physical barriers to disabled people in the built environment, existing legislation covering access to buildings does not take full account of all the needs of disabled people (Day 2005).
Although most countries acknowledge the importance of accessibility, many do not have the infrastructure or resources to make their existing services accessible.

7.3.2.6 The Thai Government

The last factor influencing the feasibility of independent living reported by the participants was the Thai government. At the time of the study, it was suspected that there has not been promotion of the independent living concept for disabled people. As mentioned in Chapter 3, the Thai government started its role in disability in 1941 by providing welfare services. Disabled people were offered places in residential homes that provided them with basic needs (Economic and Social Commission for Asia and the Pacific 1999a). Even though a vocational rehabilitation centre was later established (Economic and Social Commission for Asia and the Pacific 1999a), the role of the Thai government in disability was still on the different track to the independent living concept. Disabled people were viewed as people to be pitied. They were not able to look after themselves; and were dependent and needed help. With the instigation of the Rehabilitation of Disabled Persons Act in 1991, disabled people were recognised as an important human resource who should be provided with equal opportunities to work and participate in social activities (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991). Consequently, Thailand sought to raise awareness and disseminate knowledge about the needs of disabled people throughout the community. Even though the Thai government currently tries to improve its systems via its new legislation and plans in order to enable disabled people to live independently and be active members of society, independent living for disabled people in Thailand is in the early stage of implementation and behind other countries by many years. Therefore, it was not a
surprise that a participant in the study raised the question of whether the Thai government had played its role in disability in line with the independent living concept.

Participants discussed three aspects of the role of the Thai government relating to 'acts and regulations', 'policy and strategies', and 'ineffectiveness'. The participants considered that the Rehabilitation of Disabled Persons Act did not keep up to date and, in particular, failed to allocate money to the Fund for Rehabilitation of Disabled Persons. As a result work opportunities for disabled people were limited. According to the Rehabilitation of Disabled Persons Act (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991), the fund itself was set up to pay for expenses incurred in the implementation and provision of assistance to disabled people and support of the institutions providing medical, educational, social rehabilitation and vocational training. The Act also aimed to increase work opportunities for disabled people by requiring employers or owners of private companies to hire disabled people in an appropriate ratio to other employees (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991). However, if employers or owners of private companies preferred not to employ disabled people, they were required to donate money to the Fund for Rehabilitation of Disabled Persons using the rate designated in the ministerial regulations (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991). The effect of this concession is that companies can avoid providing employment by making a donation. As participants in the study reported that finance had a significant role in enabling disabled people to engage in independent living, being employed would be another
way to address financial restrictions. This indicated that the Act would need revision to meet the needs of disabled people regarding employment.

Recently, the Thai government introduced a new act called the Promotion and Development of Quality of Life of Disabled Persons Act A.D. 2007 to better meet the needs of disabled people (Ratchakitcha [no date]). Under the new Act, the Fund for Promotion and Development of Quality of Life of Disabled Persons has been set up (Ratchakitcha [no date]). Compared with the Fund for Rehabilitation of Disabled Persons, the new Fund has more strategies for raising money (Ratchakitcha [no date]). Furthermore, employers or owners of private companies preferring not to employ disabled people can choose to donate money to the Fund or support disabled people in activities relating to other vocational activities (Ratchakitcha [no date]). This indicates a further attempt by the Thai government to meet the needs of Thai disabled people regarding employment.

Participants also reported that the Rehabilitation of Disabled Persons Act comprised broad issues without practical guidelines and lacked monitoring and a penalty system. Although the Act served as a starting point for disabled people in their quest for greater participation and equality, there is no particular mention of practical strategies to assist disabled people to obtain equal access to public buildings for example. Furthermore, whilst this Act sought to address inequalities that currently exist for disabled people and provide some structures to support them, it does not have the penalty provisions required to encourage compliance with the legislation and enable the goals of the independent living movement to be realised. However, the Thai government has not ignored these problems. Some ministerial regulations were
established later in order to solve the problems. For example, a ministerial regulation for the national design standard of accessibility for disabled people was established and enforced in 2001 (Bureau of the Empowerment for Persons with Disabilities 2001). In 2005, a ministerial regulation for accessibility for disabled people and the elderly inside buildings was also enforced (Bureau of the Empowerment for Persons with Disabilities 2005b). As planned in the second National Plan of Quality of Life Development, the monitoring systems and penalty provisions of the law were set up in order to enforce the existing laws and regulations relating to disabled people (Office of Empowerment for Persons with Disabilities 2007). Lastly, a monitoring and penalty system was also set up in the new legislation in order to ensure that the new Act would be effective (Ratchakitcha [no date]). Again, all of these activities have shown that the Thai government has been proactive in increasing the efficiency of its legislation in order to improve life for disabled people.

Participants reported that they did not know about the policies and strategies of the second National Plan of Quality of Life Development in detail. This indicated that copies of the National Plan were not distributed to all people involved with disabled people. This might have prevented them from having a complete and clear picture of what the Thai government was doing for disabled people. This raises a concern that if the Thai government does not improve distribution of its plans in the future, works relating to disability might not progress much. Even though the copies of the National Plan was not directly sent to all people involved with disabled people, information of the plan could be accessed from the internet at www.oppd.opp.go.th, a website set up by the government organisation dealing with disability. Therefore, to enable the participants as occupational therapists to support independent living for disabled
people, they may need to use this alternative method in order to obtain important information relating to their work.

Participants also reported that the outcomes of the second National Plan of Quality of Life Development were not available even though the plan was reported to finish soon after the time of the participant interviews and had been running for approximately 3 years. They raised the point that the Plan might not have a high priority when compared with other government works. This seemed to be a valid point based on the fact that the national plan on disability was about to end. If activities in the national disability plan were not a high priority, it might be difficult to see any outcomes within its timeframe. The participants' concern was supported by Boonyarattanasoontorn et al. (2009) and a government analysis of the second National Plan of Quality of Life Development following its termination. The Thai government admitted that the success of the second National Plan could not be absolutely assessed because the plan did not have any indicators or principal organisations that had been assigned for taking responsibility for each of the strategies (Office of Empowerment for Persons with Disabilities 2007). This resulted in the plan not having any obvious outcomes (Office of Empowerment for Persons with Disabilities 2007).

Regarding the ineffectiveness of the Thai government, participants reported a 'complicated procedure', 'a lack of continuity', and 'a lack of cooperation'. According to the second and third National Plans of Quality of Life Development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a) reviewed in Chapter 3; 3.1.5.1, it seemed that these problems were acknowledged by the Thai government. They have
been trying to address the complicated procedure by providing an advisory and referral system in order to assist disabled people. Furthermore, to address a lack of continuity and cooperation, the Thai government appointed a central operating and cooperative committee in order to coordinate the administration of the Plan (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a)

In conclusion, this chapter presented participants’ opinions on the feasibility of independent living and the factors influencing feasibility. Participants in the study reported that independent living for Thai disabled people was possible even though it was difficult and needed a period of time to address the barriers existing in the Thai context. Six factors were reported to have an influence on the possibility of independent living for disabled people. These included the ‘disabled people’ themselves, ‘family’, ‘people in the community’, ‘finance’, ‘physical environment’, and ‘the Thai government’. The study indicated that it was necessary for disabled people, their families, and people in the community to develop a fuller understanding about disability and the independent living concept. In addition, financial limitations and physical barriers needed to be addressed. Furthermore, this chapter also indicated that the Thai government needed to improve dissemination of its plans and strategies and facilitate its system to work more effectively. Even though the Thai government had already addressed some of these problems, some problems remained and needed to be resolved. The next chapter will present participants’ strategies on how support should be offered in order to overcome the barriers which have been identified.
Participants’ opinions on the feasibility of independent living in Thailand and factors impacting on the feasibility were presented in the previous chapter. In this chapter and Chapter 9, participants’ opinions on what occupational therapists can offer disabled people in order to enable them to achieve the aims of the independent living concept will be presented. In the first part of this chapter, participants’ views regarding strategies and guidelines for the aims of the independent living concept relating to an individual and group context including self-direction, self-advocacy, self-help, and peer-support provision is presented. These strategies and guidelines are then discussed in detail in the second part of the chapter.

8.1 Self-direction

To promote self-direction in disabled people as stated in the independent living concept, participants suggested two actions including ‘promoting an understanding about disability’ and ‘promoting self-directed skill’.

8.1.1 Promoting an Understanding about Disability

As mentioned previously, participants reported that disabled people did not accept their disabilities and tended to depend on others. Participants suggested that to enable disabled people to be in charge of their lives, their disabilities should be accepted first. This indicated the importance of promoting an understanding of disability in disabled
people in Thailand. A comment by a participant in a re-convened group reflected the importance of accepting disability:

*I think we should encourage disabled people to accept their disabilities. This is the first thing that we should do. If they do not accept their disabilities, they will not want to do anything. They would expect to gain full recovery in the next two months or one year. They will not understand why we have to encourage them to do things for themselves.*

Another comment was:

*I thought if disabled people cannot accept their disabilities, they would not be able to determine their lives.*

In addition, participants thought that family members also should have a good understanding of disability. This would enable family members to provide appropriate support when disabled people wanted to be in charge of their lives.

To promote an understanding about disability, participants suggested that it was necessary to provide disabled people and their family members with knowledge about disability, and useful information relating to disability. A comment by a participant working in the North related to this issue:

*Knowledge is important for disabled people and their family members. We should provide them with information about disability and how to live with disability. Knowledge and information would enable disabled people to set their life goal.*

Another comment by a participant from the Central region was:

*Not only knowledge about disability and how to use their capabilities, it is necessary to provide disabled people with information about other issues relating to disability such as registration, rights, vocation, and etc.*

Some techniques were suggested for use in providing knowledge. These included 'counselling', 'peer support and role models', and the 'media'.
8.1.1.1 Counselling

Participants suggested the use of counselling to change attitudes of disabled people toward themselves. A comment by a participant working in the North related to counselling:

*Counselling from a rehabilitation team or a counsellor might be able to adjust disabled people’s attitudes. It might enable disabled people to accept their disabilities and look forward to their lives as they should be.*

Participants suggested that counselling could be provided both formally and informally. An experience from a participant working in the South in providing informal counselling was:

*I used to approach a young man with brain injury. He was quiet and indifferent. I sat next to him and gradually developed a relationship with him. It took time for him to develop trust. Once he trusted me, I began to inform him about his disability and capability. I knew that it was difficult for him to accept but he could accept his disability finally.*

Another comment by a participant working in the North-East concerned formal counselling in order to support disabled people to take charge of their lives during the transition phase:

*A counselling centre or clinic might be established in order to provide advice for disabled people who require information in any aspect of life... Counselling might be provided by a team including health professionals, social workers, vocational trainers and disabled people who have experience in determining their lives. This centre might be located anywhere either in the community or hospitals. In hospitals might be easier than in the community.*

8.1.1.2 Peer Support and Role Model

Some participants suggested using peer support and a role model for developing an understanding about disability and how to live with disability. A comment by a participant working in an academic area concerned this issue:

*Being with other disabled people and learning from them would enable disabled people to lessen the time taken to adjust to having a disability. For*
example disabled people who are discharged quickly would not have peers who could be role models. Therefore, they lack advice and support. These people always believe that their impairments are a disease that can be cured. They keep seeking other cures in order to be 'normal' [get well]. It is different from people who have experience in the rehabilitation ward. They have peers; they learn about disability from talking to people who have the same conditions as they do. This would enable them to accept their disabilities and try to do things on their own.

(Note: It must be remembered that 'normal' is not regarded as negative in Thai as it would be in English; see Chapter 3)

In addition, peer support was reported to be a more effective way of changing attitudes of disabled people rather than receiving advice from health professionals. A comment by a participant from the North reflected this issue:

\[\text{Even though we provide knowledge to disabled people in order to enable them to have a positive attitude towards themselves and disability, they sometime do not have a clear view of how they can live with disability. These people might need to talk to a person with the same physical condition who can be a role model. Talking to the role model might enable them to manage their lives.}\]

8.1.1.3 Media

Some participants proposed the use of print media in creating an understanding about disability in disabled people. A comment by a participant working in the North concerned this issue:

\[\text{In my workplace, we have brochures and books provided to disabled people. They provide general knowledge about disease, disability acquired, how an individual looks after him/herself, and necessary equipment. This information enables disabled people to have a basic understanding about their physical conditions and how to live with disability.}\]

Some participants suggested the use of audio-visual media in educating disabled people and their family members about disability. A comment by a participant working in the Central part concerned this issue:
At present, there are televisions provided for entertaining people who come to hospitals when waiting for health services. We can produce and play video tapes that provide knowledge about disabled people and what they can do.

8.1.2 Promoting Skills for Self-direction

After being able to accept disability, participants suggested two ways to promote skills for self-direction in disabled people. These were ‘supporting disabled people to find their needs’ and ‘supporting disabled people to establish and achieve their goals’.

8.1.2.1 Supporting Disabled People to Find Their Needs

To promote skills for self-direction, participants thought that it was necessary to support disabled people to find their needs. A comment by a participant had professional training in Japan reflected this issue:

Disabled people should be recognised as knowing best what they want for their lives. Some people might not want to do anything. They might have carers to look after them whilst some people might need to live independently. So, we need to know what they want.

8.1.2.2 Supporting Disabled People to Establish and Achieve Their Goals

After disabled people’s needs were identified, participants considered that it was necessary to support them in establishing their goals based on their capabilities at that time. A comment by a participant working in the North concerned this issue:

After we know their needs, we should ask them to set their goals; what they want to do as the first thing, the second, and so on. Their goals should be attainable and changeable based on their capability.

Participants thought that encouraging disabled people to think about their goals when they were in hospital/rehabilitation would enable them to attain skills for obtaining their life goals once they re-entered the community. A comment by a participant working in the North concerned this issue:

Let them set their treatment goal while in the rehabilitation ward. This might enable them to plan for their lives.
To enable disabled people to set their goals, some participants proposed using discussion groups for them and their family members. Discussion might enable them to start thinking about plans for their lives. A comment by a participant from the North-East region concerned this issue:

_We might use group therapy. We can arrange for a group of disabled people who have the same conditions and allow them to talk about any issues they want. We can include their family members in the group. This strategy might be able to make it easier for disabled people and their family members to think and plan for their lives._

However, participants reported their concern that they did not have much time to see disabled people in the hospital setting. This limited their opportunities to support disabled people and their families in goal setting. A comment by a participant working in the Central area reflected this issue:

_Normally, clients have been in general hospitals [One type of hospital providing services not for any particular disease] until their physical conditions stabilise. This might take three to five days. Occupational therapists might have a chance to see clients one day before discharge. In specialised hospitals [One type of hospital providing services for one or more particular diseases], most clients have been admitted for longer than general hospitals. It may be for about one to two months. However, occupational therapists had an opportunity to see clients for as little as one week. It's impossible for us to work with clients in setting their goals._

Participants reported that as well as helping to set disabled peoples’ goals, it was necessary to support them to achieve the goals they had set both in the hospital and in the community. Participants thought that support from occupational therapists might enable disabled people to address existing barriers and gain more confidence to live independently. Several forms of support were discussed. A comment by a participant working in the North concerned simulation or practising situations that may occur in the community setting.

_For example, if disabled people need to go into the community, we need to support them by simulating events or going into the community with them in_
the first stage. We have to work with them to address existing barriers. This would enable them to realise that they have the capability to do things and have more confidence in going back to the community.

Using role models in the real environment was also suggested in order to enable disabled people to understand adequately about how to live independently. A comment by a participant from the North reflected this issue:

*It might not make sense if disabled people only talk to their peers about how to live with disability. I think it would be a good thing if we can bring them to visit their peers in the real-life situation.*

Another participant who had experience of working with disabled people for 18 years talked about an advanced training program offered for disabled people who had difficulties in living in the community:

*In my workplace, we have an advanced rehabilitation program for disabled people who need more training. As they might not have much capability when they are discharged from the hospital, we provide them with a basic rehabilitation. After they spend their time for a while in the community and they really know what barriers there are and how much capability they have, they would ask for receiving more training. Advanced training aims to increase their capabilities in order to enable them to overcome their difficulties in the community. Disabled people would also feel confident that they have us to provide support when they need it.*

### 8.2 Self-advocacy

As mentioned in Chapter 7, participants reported that some disabled people did not take an active role in issues relating to their own lives. When participants were asked to discuss how to support disabled people to become stronger self-advocates, they suggested two kinds of action: 'promoting an understanding about advocacy', and 'supporting disabled people to advocate their rights'.

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8.2.1 Promoting an Understanding about Advocacy

Participants reported that an understanding about advocacy was important for disabled people to advocate their rights. To enable disabled people to have a good understanding about advocacy, using a role model was suggested. A comment by a participant working in the Central region concerned the use of a role model:

*We may find someone who can be a role model. We should ask the role model to talk to disabled people about advocacy and its benefits.*

8.2.2 Supporting Disabled People to Advocate Their Rights

Participants thought that it is necessary to support disabled people in order to enable them to advocate their rights. Two possible ways to support them included ‘providing information about available resources in the community’ and ‘networking and cooperating with others’.

8.2.2.1 Providing Information about Available Resources in the Community

Participants reported that information about available resources in the community was required for disabled people in enabling them to advocate for the things they wanted. A comment by a participant from the Central area concerned this issue:

*We need to provide disabled people with information about where they can ask for support when they want to advocate their rights such as disability organisations in the community. Disabled people in the organisations might want to advocate the same things.*

Collective action was reported to be more powerful than advocating rights as an individual. A comment by a participant working in the North concerned this issue:

*It would be possible to get what disabled people want if their needs are recruited and called for as a group. It would be more powerful than calls for them as individuals.*
8.2.2.2 Networking and Cooperating with Others

Participants suggested that having a network and cooperating with others was another way to support disabled people to advocate their rights. A comment by a participant working in the Central area concerned having a network with people in authority in order to support disabled people to have their rights met:

*Occupational therapists on their own will not have enough power for supporting disabled people in advocating their rights. We might have to look for support from others who have more power for example a governor and a politician.*

Another comment by a participant from the North concerned cooperation with others in having disabled people’s rights met:

*I used to belong to a committee in a provincial meeting. This meeting was set up for disabled people in order to enable them to present their demands regarding rights. Committees then considered their demands and reported these demands to the government.*

8.3 Self-help

When participants talked about self-help, they discussed this issue from the individual and group perspective. Three guidelines were suggested including ‘promoting the concept of self-reliance’, ‘encouraging disabled people to be part of a group’, and ‘maintaining support’.

8.3.1 Promoting the Concept of Self-reliance

To encourage individuals to become self-reliant, participants thought that it was necessary to encourage disabled people to improve their self-esteem. A comment by a participant who had undergone work training in Japan concerned this issue:

*Basically, we have to support disabled people to believe that they should help themselves before asking help from other people. Disabled people in Thailand tend to depend on others. They normally want other people to help them in everything rather than relying on their own.*
8.3.2 Encouraging Disabled People to be Part of a Group

Participants thought that disabled people should be encouraged to be part of a group. They proposed two methods including 'providing information about existing disability groups', and 'setting up a new group'. A comment by a participant from the Northern part of Thailand concerned providing information about existing disability groups:

We may provide disabled people with information about existing disability groups. We may have to encourage them by informing them what benefits they would get from joining the groups. However, we should let them make the decision whether they want to join the groups.

Another comment by a participant working in the North-East region concerned supporting disabled people to start a self-help group:

From my own experience, at the beginning, I realised that it would be good for disabled people to have their peers provide support for each other. So, I persuaded disabled people who had the same experience to set up a group. I explained to them about objectives, and benefits of joining the group. At first, I worked as a coordinator who invited disabled people to meet each other, looked for a place for meetings, etc. When the group had their own committee, I stepped back to act as a supporter who would provide them with any advice required.

8.3.3 Maintaining Support

After encouraging disabled people to be part of a group, the participants reported that it was necessary to maintain support for a while. Their reason for maintaining support was that disabled people were not always ready to contribute fully to a disability group. An experience by the same participant concerned why maintaining support was required:

In a self-help group, some members were active and independent but some members were not ready enough to join in the activity of the group. For example, some people have financial constraints. Some people could not go into the community alone and their carers were sometimes not available. With the passage of time, they sometimes felt discouraged about maintaining group
activities. So, we had to maintain our support until disabled people could run the self-help group themselves.

Two strategies were also required as part of maintaining support which included ‘supporting group activities’ and ‘strengthening groups’.

**8.3.3.1 Supporting Group Activities**

Participants reported that encouragement, guidelines and advice should be provided to the group on an ongoing basis. They felt that this support would enable the group’s success. For example, one participant from the North talked about providing support to a self-help group in managing a vocational activity:

> If disabled people were interested in a vocation in order to earn money for themselves, we can provide encouragement for them. We can also provide advice to them about how to ask for financial support from the Fund for Rehabilitation of Disabled Persons, and how to develop their project proposal.

**8.3.3.2 Strengthening Groups**

Some participants talked about strengthening self-help groups by providing knowledge to members of the group. A comment by a participant from the North-East area concerned this issue:

> After self-help groups are established, an OT together with other professionals may need to provide group members with knowledge they require. With members who are knowledgeable, self-help groups would come to have more strength. They would be able to run their groups without our support.

Networks were another way of strengthening self-help groups. A comment by a participant from the North concerned this issue:

> I knew that there was a link between each self-help group in order to share experiences with each other. They could learn how to run the group from another self-help group.
8.4 Peer Support

As mentioned in 8.1.1.2, participants acknowledged the benefit of peer support for disabled people. They thought that “peer support” should not be limited to disabled people. They wanted peer support among families of disabled people, and between health professionals and disabled people and their families. This meant that ‘peer’ should be taken to imply that each person had no more expertise as a supporter than any other and the relationship was one of equality. An example given by a participant from the North that reflected peer support between health professionals and disabled people is as follows:

In my workplace, there is a 24 hours counselling service provided for disabled people who are in the community. It is a rehabilitation ward project that aims to provide support to disabled people via a telephone. Disabled people are advised to ring to the ward whenever they have health problems and need advice. So, I think a peer should be anyone who can provide mutual support to another. It is like a friend giving support to another friend.

When participants discussed how to encourage disabled people to give each other support on a reciprocal basis, three strategies were reported. These included ‘providing disabled people with an opportunity to meet their peers’, ‘looking for peer counsellors and providing information for them’, and ‘providing information about available resources in the community’

8.4.1 Providing Disabled People with an Opportunity to Meet their Peers

To support disabled people in receiving and providing counselling from other disabled people, participants considered that it is necessary to provide an opportunity to enable disabled people to meet their peers while in the hospital. A comment by a participant working in the Central part concerned this issue:

In my workplace, we arrange appointments for disabled people who have the same conditions to come to our unit at the same time. For example, people
with CVA come in the morning and people with SCI come in the afternoon. This allows people who have the same condition to have an opportunity to meet each other. They talk together while receiving intervention. Disabled people sometimes get advice from others if they ask about their concerns.

In addition to disabled people, their families also provided peer support. A comment by a participant working in the Central part concerned this issue:

_As disabled people normally come with their family members, I see their family members also talking and sharing experiences together about providing care to disabled people._

Even though providing an opportunity for disabled people to meet their peers would allow them to communicate, some participants stated that this should have certain controls as some disabled people were unsuited because of, for example, being negative about independent living. A comment by a participant in a re-convened group concerned this issue:

_When disabled people come to talk together, we sometimes have to ask ourselves whether it is appropriate for them to talk together. For example, it might not be good for a person who is anxious about his/her life if he/she came to meet a disabled person who is depressed. An anxious person might not be able to accept information that a depressed person tried to tell them._

Some participants did not agree with controlling communication between disabled people. They thought that communication between individuals should occur naturally. They reported that disabled people had a right to choose who they wanted to talk to and what they wanted to talk about. A comment by a participant working in an academic area concerned this issue:

_I think we should not be involved in choosing which people may talk together. Let it occur naturally. Ok, disabled people might talk about Thai traditional medicine. Even though we know that some treatments might not good for them and the issue might not be whether to encourage them to accept their disability. We should not forget that an individual may have their own opinion. They might not believe in what their peers tell them if we provide them with correct information about disability in advance._
8.4.2 Looking for Peer Counsellors and Providing Information for Them

The provision of peer counsellors and providing information for them was another strategy suggested to support disabled people in receiving and providing peer support.

A comment by a participant working in the North concerned seeking peer counsellors.

*We work with disabled people. We know lots of disabled people. Some disabled people are independent whilst some are dependent. We might ask disabled people who are independent whether they would like to be a peer counsellor for other disabled people who need peer counselling.*

Another participant from the Central area talked about providing information to peer counsellors in order to enable them to provide appropriate counselling:

*From my experience, disabled people who could be role models were clever people. They could cope well with any situation in their lives. They could make use of information about equipment provided and make their own equipment from their local materials. So, it would be good if we could provide information to role models in order to extend their views and experiences. This would enable them to provide appropriate advice to other disabled people who need peer support.*

8.4.3 Providing Information about Available Resources in the Community

Participants reported that information about where to find peer support was important for disabled people in the community. Participants suggested that disabled people should know where they could seek peer support both in the real world and on the internet. A comment by an academic participant in a re-convened group concerned this issue:

*I agree that we need to provide disabled people with information about resources available in the community where they could seek advice and support. However, nowadays, communication can occur easily. We don't need to invite disabled people to meet each other. They can communicate to each other via the internet - for example e-mail and web sites. I used to access a website. I saw that disabled people posted up their concerns on the web site and other disabled people who had the same experience with them came to respond to what they posted. Some websites provided disabled people with chat rooms. Disabled people had their own log-in names and usernames.*
8.5 Discussion and Summary

This chapter presented participants’ opinions on the issue of how to support Thai disabled people to achieve the aims of independent living both as individuals and in the group context. Whilst self-direction and self-advocacy were the aims of independent living in an individual context, peer support was important for independent living in the group context. In this study, self-help was reported to override both the individual and the group context.

8.5.1 Self-direction

Self-direction or self-determination are terms that are used interchangeably. From the literature, they have two basic meanings (Wehmeyer and Bolding 2001). Firstly, as a phrase, it means the rights of a nation to self-government. Secondly, the term means to have control over one’s life and destiny. In this study, participants reported that disabled people should be encouraged first to accept their disability in order to support them to become self-directed people. As self-knowledge and self-awareness are important components of self-direction behaviour (Wehmeyer 1996), encouraging disabled people to accept their disabilities therefore would increase their self-knowledge and self-awareness and result in them becoming self-directed people who know what they want and can manage their lives to meet their goals.

To enable disabled people to accept their disabilities, disabled people needed to have an understanding about disability. As families were reported to have a positive impact on the feasibility of independent living for disabled people, participants reported that it was also necessary to promote an understanding about disability to family members. The participants’ consensus regarding promoting an understanding about disability in
disabled people and their family members was in line with the National Plan of Quality of Life Development (Chapter 2; 2.4.1) (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a). In addition, the necessity of promoting an understanding about disability in disabled peoples’ families was supported by Simon (2001) in his study about providing support for informal carers.

To promote an understanding about disability in disabled people and their family members, participants suggested three different methods including the use of counselling, peer support and role models, and the media. Similarly, providing counselling from the rehabilitation team and the use of peer support and role models have been reported as ways of promoting an understanding about disability in other studies (Berrol 1979; Frost 1993; Gilson et al. 1997; Hibbard et al. 2002; Simon 2001; White and Johnstone 2000). Interestingly, in this study the use of peer support and role models was reported to be more effective in promoting an understanding about disability than providing counselling from the rehabilitation team. Even though there is no evidence to enable comparisons to be made of the efficacy of these two methods, it is stated that “the able-bodied professional can provide expertise for the independent living program, but cannot provide the essential motivation or role modelling necessary to initiate progress toward independent living” (Berrol 1979: pp. 457).

Both print media and audio-visual media were regarded as another way to promote an understanding about disability in disabled people and their family members. This strategy was supported by the Thai government as stated in the third National Plan of
Quality of Life Development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a). Therefore, this strategy seems to be guaranteed in that it is supported by the government which seems to be a good sign for promoting independent living in disabled people. To produce quality media, it has been suggested that “it is necessary to follow guidelines for representation of disabled people in the media within broadcasting organisations or published by organisations both of and for disabled people” (Barnes 1997: pp 228). However, it is questionable whether there are such guidelines in Thailand. If not, it should be kept in mind at all times that the production of media may have a disabling impact if incorrect language and inappropriate terminology is used. In addition, disabled people must not be presented solely as recipients of pity.

Participants also thought that it was necessary to promote skills for self-direction in Thai disabled people. Promoting self-direction was regarded as requiring two actions: supporting disabled people to find their needs, and to set and achieve their goals. In order to support disabled people to find their needs, and to prevent failure to meet their needs, it has been suggested that health professionals should encourage the involvement of disabled people and their family members in the assessment of needs (Abbott 1999). In addition, it is necessary that definitions of need should be reached between occupational therapists and the disabled people themselves. This is supported by the study by Sim et al. (1998) about the degree of congruence between the non-disabled view of need and that of disabled people. They found that a group of disabled people tended to identify needs closer to the social model of disability than a group of non-disabled professionals.
After supporting disabled people in identifying their needs, they require support to set and achieve their goals. According to West et al. (1995), goal setting is a strategy that can foster skill at self direction. In this study, participants considered that disabled people should be encouraged to set their goals while they were still in hospital/rehabilitation. Even though their goals might involve capabilities they did not have while in hospital, participants believed that disabled people would be able to transfer their goal setting skills to set their life goals once they returned to the community. Additionally, some studies (Benz and Lindstrom 1999; Householder and Jansen 1999; Morningstar et al. 1995) have highlighted the importance of planning during the transitional phase which enabled disabled people to develop strategies for a high-quality lifestyle that provided the opportunity to live, work, and play in the community, and to have meaningful personal relationships. Therefore, adding goal setting or planning during the transition from hospital to the community in an intervention program might enable Thai disabled people to make decisions about their lives once they were back in the community. Unfortunately, study participants reported that they did not have much time to work with disabled people and family members because of shorter lengths of stay in hospital and the quick return of people to the community. This resulted in them not being able to provide support in goal setting and accomplishing goals. To deal with this problem, it is suggested that the acquisition and polishing of skills needed for successful community adaptation are greatly facilitated by the availability of good role models and by opportunities to practice needed skills with readily available social support (Spencer 1990). Therefore, it seemed that the participants' strategies for supporting disabled people to achieve their goals by using simulation situations and visiting them in the community, using
role models in the real environment, and providing advanced training programs were in line with Spencer's suggestion (1990).

8.5.2 Self-advocacy

Two actions were regarded as supporting self-advocacy for disabled people. Firstly, participants reported that promoting an understanding about advocacy and its benefits to disabled people was important and should be encouraged. This concurred with WHO's (no date) mission which advocates for the rights of disabled people in participating in their society and accessing healthcare and rehabilitation services and other supports and services necessary for their health and well-being. Whilst WHO intended to use disseminate advocacy materials in promoting an understanding about advocacy (World Health Organization [no date]), participants in the study suggested the use of role models in developing an understanding of this issue. Participants in this study strongly acknowledged the benefit of using role models in developing a deep insight about the concept of independent living.

Secondly, providing support to disabled people in enabling them to advocate their rights was reported. Participants thought that information should be provided about available resources involving advocacy rights for disabled people. Whilst the Thai government gave its commitment in the second National Plan of Quality of Life Development about supporting the establishment of advocacy organisations (Chapter 3; 3.1.5.1), participants could disseminate information about advocacy organisations to disabled people in order to enable them to advocate for things they wanted. Participants in the study also acknowledged the benefit of advocating disability rights as a group. Participants' opinion regarding advocating disability rights using
collective action correlated with the methods of independent living movements in many countries including Thailand (Braddock and Parish 2000; Finger 1999; Hasler 2003). It seemed that the participants had a very full understanding of the self-advocacy movement. They believed that disabled people should speak for themselves to reduce isolation and give them the tools and experience to take greater control over their own lives. In addition, participants suggested that another way to provide support to disabled people in advocating their rights was the use of networks and cooperation with others. Participants thought that having a network with people in authority and cooperating with others might enhance advocacy for disabled people. This indicated that the participants in the study realised the importance of linkages and cooperation between people and organisations relating to disability, which resulted in enabling disabled people to fully enjoy their lives in the community.

8.5.3 Self-help

In this study, participants suggested three strategies for supporting self-help in disabled people. Firstly, as a result of the cultural beliefs that disabled people lived physically and financially with their family members, participants reported that an understanding and belief in self-reliance should be promoted. Again, this showed that the participants acknowledged the importance of an understanding of the concept of independent living as the next step that should be promoted in disabled people following an understanding about their disability.

Secondly, according to Finkelstein (1999), disabled people in disability organisations were a vehicle for change in transformation of the disabling society. Therefore, to be a part of a mutual support group in order to improve the existing situation of disabled
people in society, participants reported that it was necessary to encourage disabled people to join existing groups or establish a new group. This was stated as an important point for health professionals and people who were involved with disabled people to highlight in helping disabled people find potential and possible connections in the community (Kelly 2002). In addition, the participants’ report was reinforced by the Thai government that aimed to promote the establishment of disability organisations (see Chapter 3; 3.1.5.1) (Office of the National Economic and Social Development Board 2006a). There are two types of disability organisations in Thailand. One is a cross-disability organisation that operates at the national level. Another is single-disability organisation that may operate at the national or provincial level. This type of organisation is formed to meet specific needs for a certain disability group, and so tends to provide more direct services to their members than cross-disability organisations. From the independent living’s viewpoint, occupational therapists should provide disabled people with enough information in order to allow them to choose their preferred organisation. With respect to establishing a new group, participants reported that they needed to take the role of coordinator in the initial period before a leader and manager could be elected for taking responsibility for running the group and reflecting the unique needs of the group members. This indicated that the participants as health professionals had a good understanding about involvement in the development of an independent living program that allowed the direction of the program to occur from within the disabled community (Berrol 1979).

Lastly, even though participants did not intend to take an executive role in self-help groups, they reported that they should maintain support for a while after initial establishing. From their point of view, this strategy would enable self-help groups to
sustain and strengthen because they believed that disabled people in Thailand still faced many personal difficulties such as poverty and mobility within the community. They also lacked management skills to run self-help groups. These difficulties might take their attention away from participating in self-help groups which would result in the self-help groups disintegrating. This concurred with the strategy suggested by the Thai government about providing support to administration of disability organisations (see Chapter 3; 3.1.5.1) (Office of the National Economic and Social Development Board 2006a).

In maintaining support to self-help groups, participants suggested two strategies including ‘supporting group activities’ and ‘strengthening groups’. To support group activities, participants provided an example of how to ask for financial support when self-help groups established new projects. This was similar to the requirement of self-help organisations in Asia and Pacific regions where assistance in fund-raising skills such as project-proposal writing was required (United Nations Economic and Social Commission for Asia and the Pacific 1997). Participants reported two ways to strengthen self-help groups, including providing knowledge to group members and networking with other groups. The participants’ concurred with the suggestion of the United Nations (United Nations Economic and Social Commission for Asia and the Pacific 1997) whereby self-help organisations in Asia and Pacific regions needed to promote communication and collaboration among the organisations.

### 8.5.4 Peer Support

In this study, participants acknowledged the benefit of peer support. Panyamee’s (2005) study also showed that receiving peer support enabled disabled people to better
adapt activities to meet their needs, expand their horizons, and feel that they had the same rights as others. In addition, participants in the study preferred an equality of relationship to occur between health professionals and disabled people, and between health professionals and family members. This was supported by Berrol (1979) in his study about the role of non-disabled professionals in the independent living program. He stated that "health professionals must provide leadership in their areas of expertise without dominance" (Berrol 1979: pp. 457). This links in with the work of Passmore et al (2008) about creating a more collaborative approach between healthcare professionals and consumers of their services. Therefore, participants in the study seemed to have a good understanding of successful involvement of all parties in the development of the independent living program for disabled people in Thailand.

Participants reported three strategies to support disabled people to receive and provide counselling to each other. Firstly, participants suggested that it was necessary to provide an opportunity for disabled people and their family members to meet and talk to their peers. The idea of this strategy sounded good even though an example given by a participant seemed to be only an informal meeting in the participant's workplace. Next, participants also suggested their role in supporting peer service provision as people who looked for peer counsellors and provided knowledge relating to health to the peer counsellors. Even though providing knowledge relating to health was an area that occupational therapists could achieve, being a peer counsellor required more than knowledge received from occupational therapists. It was suggested that the core qualities of peer counsellors should be the abilities of listening, being compassionate and a knowledge of community resources (Hibbard et al. 2002). In addition, they should have desirable characteristics including patience, tolerance, consistency of
contact, honesty about the counsellor's own negative feelings, emotional stability, respect for disabled people and the family's experience, and capacity for in-person contact (Hibbard et al. 2002). In other countries, peer service provision is formally organised by organisations (Brown 2005). These organisations normally provide recruitment and training of individuals to provide peer support, recruitment of individuals and family members in need of peer support, creation of mentoring partnerships, technical assistance, and program evaluation (Hibbard et al. 2002). Therefore, to support peer service provision, participants as occupational therapists may need to network with disability organisations that provide peer support service and collaborate with those organisations in developing a peer service program. Even though the two strategies suggested by participants seemed to have a limited scope, the third strategy regarding providing information about available resources in the community for disabled people was admirable. This latter strategy would lead to successful involvement in the development of the independent living program that encourages Thai disabled people to take control of their own lives.

In this study, there was argument between participants' opinions regarding having some control on communication between disabled people particularly in allowing some people to meet and talk. In Hibbard et al.'s (2002) study, a team of peer service people took responsibility for matching disabled people with counsellors who the team believed best met the individual's needs. However, some disabled people in their study requested better matches. In considering the concept of independent living where disabled people should have full control of their lives, it seems it would be better if disabled people had freedom to choose their peers who would give them advice and support.
In conclusion, this chapter presented and discuss participants' opinions about how support should be offered to Thai disabled people in order to enable them to become self-directed and self-advocated people. It also included how to support disabled people on the issues of self-help and peer service provision. In this study, the importance of understanding disability and the concept of independent living were highlighted to be the primary issues that should be promoted to disabled people and their family members. Many strategies were also suggested to support disabled people in achieving the aims of the independent living concept regarding self-direction, self-advocacy, self-help, and peer service provision. Some of these strategies could be accomplished by occupational therapists but some strategies required cooperation and collaboration with others including other disabled people who could be role models, disability organisations, and non-disabled people involved with disability.
Chapter 9
Support from Occupational Therapists
in the Wider Cultural Context

Chapter 8 presented the support occupational therapists believed disabled people should have in order to achieve the aims of independent living in the individual and group contexts. This chapter presents and discusses support from occupational therapists in issues relating to the wider cultural context. These include the issues of consumerism, equal rights, and removing social barriers. Similar to previous chapters, this chapter is organised in two parts. The first presents the results which show themes and sub-themes extracted from the participants’ views. The second part discusses their points of view in relation to the literature.

9.1 Consumerism

The participants regarded consumerism as generated from Western culture. They felt that it was difficult to support Thai disabled people’s decisions as to what service they wanted. Participants talked about their reasons particularly concerning health care services required. Two reasons that were raised included the ‘health professional-client relationship’ and ‘free health care services’. A comment by a participant working in the Central area concerned the health professional-client relationship:

*In Thai culture, doctors are respected in the same way as a god and clients should not resist a doctor on any kind of issue. This belief is also applied to the relationship between clients and all other health professionals. It is different from Western culture where clients can sue doctors if doctors do anything wrong. In Eastern culture, clients believe that doctors deliver them from illness and death. They are under an obligation to doctors, and they would not dare to blame or sue doctors.*
Another comment by an academic participant concerned free health care services:

\begin{quote}
It is possible if we pay for services with our own money; we can choose what we want. However, Thailand has a welfare system for providing health care services to disabled people. Everything is free [for registered disabled people]. I think it is difficult to encourage Thai disabled people to take a consumer role in order to ask for things they want. Disabled people have to accept what services are provided.
\end{quote}

However, some participants reported that there was evidence that showed a change in disabled people from being passive to active consumers. Disabled people appeared to have more knowledge about consumerism and more readiness to choose things they wanted than in the past. A comment by a participant working in the Central part concerned this issue:

\begin{quote}
In my experience, I have seen some disabled people asking for changing the health professionals who provided services. Some disabled people also could ask for more information. This indicated good progress in disseminating knowledge about the consumerism concept.
\end{quote}

To support disabled people to take a consumer role according to the independent living concept, three strategies were discussed. These included ‘promoting an understanding about the consumerism concept in health professionals’, ‘promoting an understanding about the consumerism concept in disabled people, and ‘providing support to disabled people to take a consumer role’.

\subsection*{9.1.1 Promoting an Understanding about the Consumerism Concept in Health Professionals}

Participants thought that it was necessary for all health professionals to first understand the consumerism concept. They believed that this understanding would be able to shift the control of decision making from health professionals to disabled people. A comment by a participant working in the North concerned this issue:
If all health professionals accepted clients as central to decision making, it would be great for disabled people to take a consumer role. However, some health professionals do not understand their roles. They forget that disabled persons should be the best people to select services they want.

Thus, health professionals required knowledge about the concept. One academic participant stated that knowledge about the consumerism concept should be entrenched in student health professionals:

_We should encourage health care students in believing that we are service providers. We cannot make decisions for anyone. We should provide clients with information and leave them to decide what they want._

9.1.2 Promoting an Understanding about the Consumerism Concept in Disabled People

To enable disabled people to take a consumer role, a fuller understanding about the consumerism concept among disabled people was considered to be a prerequisite. Certain strategies were proposed. Most participants suggested the use of verbal information. A comment by a participant working in the Central area concerned the use of verbal information:

_When disabled people come to see us, we could inform them that they have the right to choose what they want. They also should know how to behave if they are not respected as a consumer._

Using other media was also suggested. A comment by a participant working in the North-East concerned this issue:

_We have seen the success of several campaigns that used media promotions. So, if we promote the consumerism concept via television, brochures, and so on, that would probably enable disabled people to realise that they are persons who can choose what they want._
Another participant from the North suggested encouraging disabled people to join disabled peoples' groups in order to receive information about the consumerism concept from their peers.

9.1.3 Providing Support for Disabled People to Take a Consumer Role

Support for disabled people was considered necessary to enable them to become active consumers. To do this, three strategies could be undertaken including 'changing the perception of occupational therapists towards disabled people', 'providing enough information and allowing disabled people to choose', and 'allowing disabled people to provide feedback'.

9.1.3.1 Changing the Perception of Occupational Therapists towards Disabled People

Participants reported that the perception of disabled people among occupational therapists should be changed. Disabled people should be view as clients who could take control of services provided rather than patients who was a recipient of what service provided. A comment by a participant working in an academic area concerned this issue:

*We should adjust ourselves first. Don't view them as patients but view them as clients.*

Another comment by a participant having had training experience in Japan extended this issue:

*We need to throw off thinking that disabled people are persons who need rehabilitation all the time. We need to view disabled people as a person who sometimes require advice. So, we should not do anything for disabled people if they do not ask.*
In addition, viewing disabled people as experts was proposed. A comment by an academic participant concerned this issue:

*We normally view ourselves as the provider. However, we need to view ourselves as a receiver as well. We should respect disabled people as experts who know what is best for their lives. They know what is appropriate for them. This would equip us to provide services to satisfy the needs of disabled people.*

9.1.3.2 Providing Enough Information and Allowing Disabled People to Choose

To enable disabled people to make decisions on what they wanted, participants reported that information about possible choices should be provided. A comment by a participant from the North-East area concerned this issue:

*Regarding health services, if we want disabled people to choose services they want, we need to provide them with enough information in order to enable them to make decisions. This was not only occupational therapists, but also other health professionals and staffs in the hospital need to provide them with enough information.*

9.1.3.3 Allowing Disabled People to Provide Feedback

To enable disabled people to be active consumers, participants thought that evaluation of services and providing feedback to service providers should be offered to disabled people. A comment by a participant working in an academic area concerned this issue:

*It is necessary to support disabled people to evaluate our services according to whether they are satisfied or not. Evaluation on this basis would allow them to make decisions as to whether they want to continue receiving services or terminate services.*

Another example by a participant working in the Central area concerned offering an opportunity to disabled people to provide feedback to a hospital:

*Disabled people, who are not satisfied with services received, can report to my workplace and ask for a new health professional.*
9.2 Equal Rights

When participants were asked to discuss how to support disabled people to have the same rights with other people, they suggested two strategies including ‘promoting an understanding about disability rights’, and ‘providing support to disabled people to exert their rights’.

9.2.1 Promoting an Understanding about Disability Rights

Participants reported that an understanding about rights in disabled people was essential in enabling them to exert their rights. A comment by a participant working in the North concerned the importance of an understanding about rights:

Before enabling disabled people to exercise their rights, they should know and understand what they are entitled to as a citizen under the laws and regulations of the country.

In addition to disabled people, participants thought that families of disabled people should understand about disability rights. A good understanding about disability rights was regarded as a way of enabling family members to provide appropriate support to disabled people when disabled people exercised their rights. A comment by a participant from the North-East concerned this issue:

I think family is important for disabled people. Family members could encourage disabled people to feel that they are capable of asserting their rights. So, family members should have an understanding about disability and disability rights.

In that case, an understanding about disability rights would be required for disabled people and their family members. Participants suggested that the information might be provided by occupational therapists themselves, or other people who had knowledge about disability rights. A comment by a participant from the Central part concerned this issue:
If we can, we should provide disabled people and their family members with information about disability rights. Alternately, we might encourage them to participate in disability groups. I know that disabled people who join disability groups normally acquire knowledge about disability rights.

9.2.2 Providing Support to Disabled People to Assert Their Rights

To support disabled people to assert their rights, participants suggested four techniques including ‘supporting disabled people to get a sense of equality’, ‘preparing disabled people to be ready for exerting rights’, ‘providing disabled people with information about available resources in the community’, and ‘cooperating with others’.

9.2.2.1 Supporting Disabled People to Get a Sense of Equality

Participants considered that it was necessary to encourage disabled people to feel that they had the same rights as others. This could be undertaken through interaction between health professionals and disabled people. A comment by an academic participant concerned this issue:

Regarding interaction between health professionals and disabled people, if we respect them and treat them like anyone else, it would be the starting point for disabled people to perceive that they are deserving and have the same rights as others.

9.2.2.2 Preparing Disabled People to be Ready to Assert Their Rights

Capability was regarded as having importance for disabled people to exercise their rights. In this study, participants thought that it is necessary to support disabled people to be ready to assert their rights. One academic participant said:

To assert their rights in any aspect, disabled people need to have enough capability. Occupational therapists can provide them with interventions in order to enable them to have necessary skills for asserting their rights. For example, some disabled people may need to study. They may require skills and further equipment for writing.
9.2.2.3 Providing Disabled People with Information about Resources Available in
the Community

Participants reported that information about resources available in the community was
necessary if disabled people were to assert their rights. A comment by a participant
working in the South concerned this issue:

As far as I'm concerned, I think we should provide disabled people with
information about resources available for involvement with disability rights.
This information is necessary for them when they need to assert their rights.

Resources relating to other aspects of life were raised, such as additional useful
information. A comment by a participant working in the North concerned this issue:

We should provide disabled people with information about available
resources such as where to ask for a free wheelchair or financial support, and
where to get vocational training. This information would enable disabled
people to exercise their rights further.

9.2.2.4 Cooperating with Others.

Participants reported that cooperation was required in order to support disabled people
to exert their rights. Cooperation among health professionals was needed and between
health professionals and people in authority, and also between health professionals
and organisations. For example, a comment by a participant working in the Central
part concerned cooperation among health professionals in enabling disabled people to
get free health services:

According to the Rehabilitation of Disabled Persons Act, registered disabled
people are entitled to receive free health services. I used to ask a physician to
complete a government document for disabled people to confirm the
impairment conditions. This enabled disabled people to be registered and get
free health services.
Another comment by a participant from the North-East region concerned cooperation between health professionals and the head of community in supporting disabled people to exert their rights.

We might investigate what disabled people think that they do not have the same rights with others. We then report this investigation to the head of community. This would enable the head of community to manage government support to serve the rights of disabled people.

Another comment by a participant from the North concerned cooperation between health professionals and organisations in enabling disabled people to exert their rights on the issue of employment.

We should have links or networks with other organisations such as special schools, and vocational centres. When disabled people want to access these services, we can refer them to these organisations. I consider it difficult for them to access other services without support.

9.3 Removing Social Barriers

In this study, participants discussed two types of social barriers that prevented disabled people from being independent. One was social attitudes, and the other was physical barriers.

9.3.1 Social Attitudes

To enable disabled people to enjoy their lives in the community, participants suggested two strategies for dealing with social attitudes. These included ‘promoting an understanding about disability in people in the community’, and ‘building positive attitudes toward disabled people’.
9.3.1.1 Promoting an Understanding about Disability in People in the Community

Participants reported that it was necessary to create an understanding about disability in people in the community. They thought that more understanding about disability would enable people in the community to accept disabled people. A comment by a participant working in the North concerned the benefit of having an understanding from people in the community:

Even though disabled people have a positive attitude toward themselves, they still need other people in the community to understand them and have positive attitudes towards them. Receiving support from people in the community would enable them to become mentally stronger and live in the community like other people.

Some other particular groups of people that should be encouraged to have a good understanding about disability were reported. A comment by a participant from the Central part concerned developing an understanding in health professionals:

We need to encourage colleagues and other health professionals in our workplace to have positive attitudes towards disabled people.

Another comment by a participant working in the North concerned developing an understanding in employers.

Some disabled people have enough capability to work. We need to promote an understanding about disability in employers in order to enable them to provide opportunities for disabled people to work.

To promote an understanding about disability, participants suggested some strategies for providing knowledge. Some participants proposed using of visual media. A comment by a participant from the Central part concerned this issue:

We could produce a video tape about disabled people who can live independently. Besides, we should add information about organisations that provide support for disabled people. We might play this video tape anywhere, in our unit, hospital, and community.
Another comment was:

*We may try to encourage a TV program to telecast life experience of a disabled person who can live independently.*

Some participants suggested the use of outreach services in order to build an understanding about disability in people in the community. A comment by a participant working in the North-East of the country concerned this issue:

*We might go into the community. We might approach the community head at first. We would provide him/her with information about disability, disability rights, and how to support disabled people to have a good quality of life. This might enable him/her to provide appropriate advice for other people in the community in responding to disabled people.*

Some participants talked about promoting a good understanding of disability in the younger generation by providing direct experience. A comment by a participant from the North-East region concerned this issue:

*It would be good for people to get familiar with disability from a young age. I know that some occupational therapists are invited to serve on a school committee. We might take this opportunity to invite schools to bring students to visit disabled people sometimes.*

### 9.3.1.2 Building Positive Attitudes towards Disabled People

Two methods were recommended for building positive attitudes towards disabled people in members of the community. Some participants suggested the use of community-based rehabilitation (CBR). A comment by an academic participant concerned CBR:

*CBR should be implemented in the community. Not only disabled people and members of their family, but also members of the community should be recruited to take part in CBR. This would enable them to have a good understanding about disability and have positive attitudes toward disabled people. Village Health Volunteers, who represent the primary health care service organised at the community level, could provide a key person for running CBR. A temple may be used as a centre for disseminating the CBR concept to people in the community.*
Encouraging disabled people to show their capabilities was reported as another way for building positive attitudes towards disabled people in members of the community.

A comment by a participant working in the Central area concerned this issue:

_We need to encourage disabled people to show their capabilities to people in the community. We could support them in participating in community activities. This may enable people in the community to accept disabled people as a part of the community._

### 9.3.2 Physical Barriers

Participants suggested three strategies for removing physical barriers from the community. These strategies included ‘cooperating between professionals involved with accessibility’, ‘providing support for disabled people to go into the community’, and ‘providing support to disability groups in asking for accessibility’.

#### 9.3.2.1 Cooperating between Professionals Involved with Accessibility.

To enable disabled people to enjoy their lives in the community, participants reported that occupational therapists and other professionals involved with accessibility for disabled people should work together. A comment by a participant working in an academic area concerned this issue:

_Nowadays, we don’t know exactly who has responsibility for accessibility for disabled people. Architects said that they designed buildings according to their principles and theory. Occupational therapists said we evaluated buildings in terms of function and whether disabled people could access those buildings. I think if both sets of professionals can cooperate with each other, disabled people might have access to go into the community easier than at the present._

#### 9.3.2.2 Providing Support for Disabled People to Go into the Community

To enable disabled people to go into the community, participants reported that environmental adaptation was required both in the community and in their dwellings. In the community, participants stated that it was necessary for heads of communities
who control government budgets to have an understanding of what the disabled required. A comment by a participant from the North-East concerned this issue:

If we can approach the community head, we can provide him/her with information about disability and how to support disabled people to go into the community. We know that the community head is a person who is in charge of making allocations from a government budget. If he/she realises the importance of disabled people as a part of the community, he/she might allocate some of the budget in order to adapt the environment to give disabled people access to the community.

Environmental adaptation was also needed in the houses of disabled people. A comment by a participant working in the North concerned this issue:

We need to provide information about home modification to disabled people in order to enable them to have access anywhere in their houses and outside their houses.

If environmental adaptation was impossible, assistive devices were reported as an alternative strategy for disabled people's access in the community. A comment by a participant working in the North concerned this issue:

We sometimes cannot make a considerable change in architecture. We may have to provide disabled people with assistive devices in order to enable them to have access to their community.

9.3.2.3 Providing Support to Disability Groups in Asking for Accessibility

To remove physical barriers existing in the community, participants reported that disabled people's needs should be reported to the government via disability groups. A comment by a participant working in the North concerned this issue:

We should encourage disabled people to inform disability groups about their difficulty in accessing public places. Disability groups would collect and report this information to the government in order to ask the government to take action in compliance with its law and regulations.

Participants felt that disability groups should ask the government for a monitoring system to determine whether public places conformed to the Rehabilitation of
Disabled Persons Act and its regulations in providing accessibility for disabled people. A comment by a participant who had working experience of 18 years concerned this issue:

*It would be effective if the government would set up a monitoring system to check whether there are means of access provided for disabled people to access those buildings. If there is no means of access, the government should compel provision of means of access in those buildings. This should be initiated by disabled people themselves. They should ask disability groups to pressure the government to establish a monitoring system.*

A system of sanctions was also considered necessary in order to enforce accessibility provision for disabled people. A comment by a participant working in an academic area concerned this issue:

*Currently, there is no system of sanctions for companies or owners of public buildings that do not confirm to the Act and its regulations. We should encourage disability groups to ask the government to revise the Act and its regulations in order to have a system of sanctions.*

9.4 Discussion and Summary

The occupational therapists' opinions about what support they could provide to disabled people to engage with the concept of independent living with respect to consumerism, equal rights, and removing social barriers have been presented above. This section presents the discussion of these issues.

9.4.1 Consumerism

In the study, consumerism was felt to be an aspect of independent living in the West. Participants reported that it was difficult for Thai disabled people to be active consumers if they could not decide what products or services they wanted to receive, particularly on issues relating to health. This was a similar finding to Panyamee's (2005) study about independent living for disabled people in Thailand. She found that
participants had low expectations of health services, did not know what was available and were not able to take an active role in requesting services and how services were delivered.

As discussed previously, the typical Thai value system could dissuade Thai disabled people from being self-assertive (Komin 1990). Participants in the study also discussed two other factors that influence Thai disabled people when required to take an active consumer role. Professional-client relationships were reported to be the first one. In Thailand, health professionals have been held in very high regard and respect and have been entrusted with control of the provision of services. This also included occupational therapists who have tended to provide their practice based on the medical model of disability, wherein the power of decision-making was controlled by the health professionals (Pongsaksri 2004) rather than the service consumer. This was similar to other countries where professional-client relations have been unequal over the last century (French and Swain 2001). However, in the last thirty years, health services in Western countries have increasingly emphasised client autonomy in decision-making. Clients have been offered opportunities to take an active role in consumerism. Therefore, it seems to be necessary for health professionals in Thailand including occupational therapists to bring about accommodation of the current perception of professional-client relationships to consumerist frame of mind in the health service system.

Another factor was free health services for disabled people in Thailand. The participants reported that the use of free health services resulted in disabled people being compelled to receive what services were provided rather than what they wanted.
A good example from a participant concerning this issue was about the issue of assistive devices (see Chapter 7; 7.2.6.3). In Thailand, registered disabled people can ask for assistive devices to be supplied, repaired and maintained free of charge (Rehabilitation of Disabled Persons Act and Ministerial Regulations Rehabilitation of Disabled Persons Act 1991). At present, the Sirindhorn National Medical Rehabilitation Centre, Ministry of Public Health, is the central agency managing assistive devices (Asia-Pacific Development Center on Disability 2005). The centre uses standard specifications for assistive devices and service provision (Economic and Social Commission for Asia and the Pacific 1995a). Consequently, the types of assistive devices available are limited. Disabled people are not able to access tailored solutions that may be necessary for them such as a reclining wheelchair or an electric wheelchair. Evans (2002b), the president of the European network of independent living, concurred and stated that it was difficult for disabled people to have much control and choice over free services received from their country's government. On the other hand, it was remarked that the purchaser position would enhance choice, control, autonomy and independence in disabled people (Morris 1993).

In Thailand, the government may need to consider how to increase work opportunities for disabled people and/or increase financial support for disabled people in order to enable them to be in the purchaser position to control decisions over services and goods they want. Otherwise, the Thai government may need to be more flexible and expand its current funding to cover the items necessary for health services in order to meet the individual needs of disabled people. In the second National Plan of Quality of Life Development (Office of the National Economic and Social Development Board 2006a), disabled people would receive financial support in order to enable them
to buy assistive devices and equipment independently if assistive devices provided by
the government did not match their needs (see Chapter 3; 3.1.5.1).

Even though it seemed to be difficult for Thai people to take a consumer role, a
change in disabled people from being passive to active consumers has been noticed.
This tendency seemed to signal a favourable prospect for independent living in
Thailand. Therefore, to encourage Thai disabled people to be active consumers,
participants reported that it was necessary to promote an understanding about the
concept of consumerism. Three methods for promoting an understanding were
suggested. These included providing verbal information by health professionals, the
use of media, and the involvement of peers. Whilst receiving knowledge from their
peers and receiving knowledge from health professionals may be suitable for dealing
with individuals or some disabled people, the use of media may be a better way to
promote the consumerism concept in disabled people at large. There is also a
necessity to promote the consumerism concept in health professionals in Thailand.
Having knowledge about the consumerism concept might enable health professionals
to support disabled people to take a consumer role. However, in a recent study, the
importance of training service providers to offer greater choice to disabled people has
been highlighted (Cooper and Browder 2001). Therefore, providing knowledge
together with training might ensure that occupational therapists in Thailand can
provide services in ways which could accommodate consumerism.

Apart from promoting an understanding, participants also suggested some strategies
for supporting disabled people to take a consumer role. These included viewing
disabled people as experts who knew and could decide on what was the best for their
lives, providing them with opportunities to make decisions on services they wanted and provide their feedback to service providers. These strategies may be able to bring about an accommodation of the current perception of professional-client relationships to an atmosphere of consumerism in health services. Providing feedback to service providers was supported by the second National Plan of Quality of Life Development. It encouraged disabled people and their family members to participate in monitoring and assessing health services (Office of the National Economic and Social Development Board 2006a). It seems signal favourable prospects for promoting consumerism in Thailand because disabled people would become active consumers.

9.4.2 Equal Rights

In the study, participants discussed two main strategies for supporting disabled people to exercise their rights. Firstly, participants reported that an understanding about disability rights was necessary for disabled people and their family members. Again, this highlighted the significance of information and knowledge about the independent living concept in empowering Thai disabled people to live more independently. This also reflected the importance of family as a supporting resource in enabling Thai disabled people to be independent. Participants thought that knowledge and information about rights could be directly provided by health professionals. Alternatively, disabled peers were valued as an important resource in the community in enabling disabled people to develop a fuller understanding about disability rights. These methods might be able to raise disabled people’s awareness regarding disability rights. It indicates that occupational therapists and disabled people in disability organisations in Thailand need to prepare themselves to be ready for providing knowledge and information to disabled people and their families. This strategy was
supported by the second National Plan of Quality of Life Development (Office of the National Economic and Social Development Board 2006a) (see Chapter3; 3.1.5.1).

Participants thought that it was necessary to support disabled people to exert their rights in both direct and indirect ways. Participants reported that health professionals should encourage disabled people to have a sense of equality via their direct interaction. This was similar to Biehal's (1993) opinion in a study about the possibilities for participation in community care. She stated that the rights of service users as citizens can be promoted via equality in relationships between professionals and users. Class, ethnic origin and gender should not limit the social power of service users and undermine their rights to full citizenship. In addition, she suggested that enhancing participation in decisions about the services they used would empower service users to gain a sense of their rights. Therefore, using appropriate ways to approach and increase participation for disabled people in providing services might enable disabled people in Thailand to gain a sense of equal rights.

The other two direct methods were preparing disabled people to exert their rights and providing them with information about available resources in the community. These strategies corresponded with the basic premise of the independent living movement which stated that to enable disabled people to be integrated as fully as possible into their communities, their needs could be met most effectively by comprehensive programs which provide a variety of services (Berrol 1979). Therefore, the participants' report is promising for disabled people in Thailand if they are provided with services and information that enable them to exert their rights.
Participants realised the importance of cooperating with others and various organisations in enabling disabled people in Thailand to have equal rights. If occupational therapists were linked in networks for cooperation with other professions and organisations relating to disability rights, it might enable disabled people in Thailand to assert their rights more readily.

9.4.3 Removing Social Barriers

To enable disabled people to enjoy their lives in the community, social barriers needed to be removed. Participants discussed this issue including social attitudes and physical barriers.

9.4.3.1 Social Attitudes

Participants suggested two strategies to change social attitudes including promoting an understanding about disability in people in the community and building positive attitudes towards disabled people in people in the community. Their suggestions were in line with the second and third National Plan of Quality of Life Development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a) as described in Chapter 3; 3.1.5.1 Providing information and knowledge to people in the community would build acceptance and enable provision of appropriate supports and opportunities for disabled people to fulfil their lives in the community. In addition, health professionals and employers were groups of people that, according to the participants, needed a fuller understanding of disability. It was possible that the participants as occupational therapists promoted understanding in health professionals because they might experience discrimination towards disabled people in their work place. Tighe’s (2001)
study highlighted the impact of the attitude of health professionals on disabled people when receiving health services. Promoting understanding in employers was called for on the grounds that most disabled people in Thailand were not employed and had difficulty in obtaining work opportunities. Other studies (Householder and Jansen 1999; Lee et al. 1994; Reed and Rumrill Jr. 1997), showed that promoting understanding about disability was used as a strategy to remove negative attitudes towards disabled people among health professionals and employers. Therefore, if these groups of people had a fuller understanding of disability, it would enable disabled people to assert their rights at least in receiving health services and employment.

Participants suggested using visual media, outreach services, and providing direct experience about disability to the younger generation as methods of promoting an understanding about disability in people in the community. These methods concurred with the Thai government's methods regarding the use of media, activities, and education in the community for promoting positive attitudes towards disabled people (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a) (see Chapter 3; 3.1.5.1). Guidelines for the production of visual media and its benefits were discussed in Chapter 8 (8.5.1) and in this chapter (9.4.1). Participants considered that providing outreach services within the community was necessary, and heads of communities were designated as key people in promoting an understanding about disability. In Thailand, community leaders have been made responsible for initiating community development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a). The participants held the opinion that if the
head of a community had a good understanding about disability, he/she might encourage other people in the community to understand and accept disabled people as a part of the community. This conformed with the statement that public awareness especially awareness of leaders is a very important factor in the attainment of independent living by disabled people (Oka 1988). If a leader's response to disability was negative, community activities to promote independence of disabled persons would be hindered (Oka 1988). Apart from promoting an understanding of disability in people in the community via the use of outreach services, the younger generation was considered to be a group of people that should be encouraged to have an understanding of disability. Participants believed that receiving direct contact with disabled people would enable the younger generation to grow up to be people who understood about disability.

Participants commended CBR as a way of encouraging disabled people to demonstrate their capabilities to people in the community and build positive community attitudes. This was supported by the study of Cheausuwantawee (2005) highlighting the positive aspects of CBR in Thailand regarding promoting the positive attitude of society and community towards people with disabilities even though all of CBR projects being implemented in Thailand at the time of his study were in the form of outreach services. WHO has used CBR for two and a half decades to promote collaboration among community leaders, disabled people, their family members, and stakeholders in equal opportunities for all disabled people in the community (World Health Organization 2004). One of major objectives of CBR is to activate communities to promote and protect the human rights of disabled people through changes within the community, for example, by removing social barriers to
participation (World Health Organization 2004). Therefore, the participants’ support for CBR in creating positive attitudes towards disabled people in members of communities was wholly in accord with the WHO CBR strategy. Demonstrating disabled people’s capabilities in the community has enabled people to have positive attitudes towards disabled people. The UN attempted to increase public awareness about disabled people by encouraging disabled people to increase their inclusion and create independence (Economic and Social Commission for Asia and the Pacific 1999b). Even though all methods regarding promoting an understanding about disability and building positive attitudes towards disabled people suggested by participants in the study seemed to work well, other methods might need to be created.

9.4.3.2 Physical Barriers

Participants considered that cooperation between professionals who were involved with accessibility for disabled people needed to be promoted. Whilst architects were reported to be involved in building design, functional evaluation of the built environment and its modification in order to enable access for disabled people were reported as an occupational therapists’ role. Participants thought that collaboration and cooperation between these professionals would enable them to provide services to meet the need of disabled people. According to the UN report regarding promotion of non-handicapping physical environments for disabled people in Asia and Pacific region, it is stated that a generally high level of education of planners, architects and building technicians is no guarantee of accessibility in many countries. Access issues are often neglected in the curriculum (Economic and Social Commission for Asia and the Pacific 1995b). Therefore, collaboration and cooperation between professionals
who are involved with accessibility issues might be able to educate the professionals concerned about accessibility.

In addition, environmental adaptation and providing assistive devices were recommended as ways whereby occupational therapists could support disabled people to enter the community. Even though environmental adaptation and providing assistive device are unique roles of occupational therapists, participants looked to cooperation from heads of communities. In Thailand, there are three basic levels of public administration: central, provincial, and local (Tummakird 2003). Local administration is used to manage affairs at the community level (Tummakird 2003). It is based upon the concept of decentralisation, which allows local people to participate in local affairs under certain laws and regulations (Tummakird 2003). Therefore, the heads of communities seemed to the participants to be the appropriate officials for occupational therapists to approach to make changes in the community environment to suit disabled people.

Participants reported that disability organisations should be used as advocates for press for accessibilities that disabled people wanted. In addition, participants reported that disability organisations should lobby the Thai government to have monitoring and penalty systems in place to enforce all public places to provide accessibility for disabled people. This was supported by the study of Fleming Cottrell (2005) who suggested that to enable disabled people to attain full participation in life, occupational therapists should joint with the disability right movement to advocate for the major systemic changes. This is also in line with UN policy in promoting a non-handicapped physical environment for disabled people stating “Public control is a
necessity. Without the strong democratic influence of users and their organisations, the goals of an accessible society will never be reached” (Economic and Social Commission for Asia and the Pacific 1995b: pp. 5). Therefore, to ensure that all facilities and services in the built environment are convenient, safe and usable by disabled people, participants as occupational therapists should provide support to disabled people and disability organisations in order to enable them to lobby for accessibilities they want. However, the Thai government also acknowledged the importance of laws and regulations in removing physical barriers. As stated in the second and third National Plan of Quality of Life Development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a), the Thai government attempted to develop and improve laws and regulations relating to accessibility for disabled people to be more efficient (see Chapter 3; 3.1.5.1). Therefore, there is a basis in legislation for disabled people and disabled peoples’ organisations to call for improvements in accessibility.

In conclusion, this chapter brought together participants’ beliefs about how services should be offered to disabled people in order to enable them to achieve the aims of the independent living concept that related to consumerism, equal rights, and removing social barriers. Promoting an understanding about disability and the independent living concept was felt to be important for disabled people, their families, people in the community, and health professionals. Several strategies were recommended to provide knowledge and promote understanding. Participants also thought that disabled people required support in order to engage with each component of the independent living concept - consumerism, equal rights, and removing social barriers. Even though
participants mainly discussed what they could do to support disabled people to live independently, cooperation and collaboration from disabled people themselves, their families, people in the community, and other professionals relating to disability, disabled peoples' organisations, and the Thai government were perceived as important in enabling disabled people to engage in independent living.
The participants' opinions regarding support that should be offered to disabled people in Thailand in enabling them to engage independent living have been reported and discussed. This chapter presents and discusses the conceptual models that participants consider are a basis for the independent living concept. It also details principal requirements for occupational therapists who need to deal with disabled people seeking independent living. This chapter is divided into two parts. Firstly, the themes and sub-themes that emerged from the participants' sessions regarding models and requirements are presented and are then discusses in relation to the literature.

10.1 Conceptual Models Supporting the Independent Living Concept

When participants were asked to discuss suitable models for independent living, they expressed varied opinions. Some participants thought that the client-centred model could serve the philosophical assumptions of the independent living concept regarding self-direction and consumerism. A comment by a participant working in the North concerned this issue:

*Concerning self-direction, the first initiative must come from disabled people. We cannot determine what they should do. It is necessary to encourage them to understand and accept their disability. We then should provide them with information necessary for enabling them to decide about what they want for their lives. All of these aspects are in the client-centre framework.*
However, some participants argued that the occupation-based model was also compatible with the independent living concept. A comment by a participant working in an academic area concerned this issue:

*Don’t forget our role. We deal with people in the area of occupation. We should follow client-centred practice together with occupation based models for supporting disabled people to achieve independent living and gain quality of life.*

Even though the client-centred and occupation-based models were reported as suitable models in enabling disabled people to engage in independent living, the importance of the medical model of disability was also acknowledged for use particularly in acute phases of impairment. A comment by a participant working in an academic area concerned this issue:

*In fact, we provide services to disabled people from the time they are admitted until they are discharged. Without a doubt, we have to use several models as frames of reference for practice according to the clients and their situations. We may have to use the medical model to be a frame of reference when dealing with clients in an acute phase. However, we cannot use only the medical model. The medical model focuses on impairments rather than the needs of a person. Therefore, it could not support disabled people to live independently as much as occupation based models.*

### 10.2 Requirements for Occupational Therapists

As mentioned in Chapter 6, participants reported that occupational therapists should take a supporting role in enabling disabled people to be independent. To enable occupational therapists to take that role, some requirements for occupational therapists were required and covered such issues as ‘working in the community’, ‘skills’, ‘knowledge and information’, and ‘being interested in clients’ contexts’.
10.2.1 Working in the Community

Some participants reported about expanding their services into the community. A comment by a participant from the North concerned this issue:

*We need to adjust how we work. We should not be service providers only in hospitals. We should go into the community and have a look at how we can support disabled people to enable them to live independently. This would result in disabled people gaining more confidence to live in the community.*

Another example by a participant working in the South related to visiting disabled people during a transitional period:

*Disabled people may not be able to live independently after they are discharged. We may need to continue our support in the earliest stages. We should visit them and see whether they can adjust their lives to be with disability.*

10.2.2 Skills

Counselling skills were said to be necessary to enable occupational therapists to counsel disabled people and their families. A comment by a participant working in the North concerned this issue:

*I think we lack counselling skills. We have to deal with disabled people. Each one has their own problems and concerns. So, we need counselling skills so that we can provide disabled people with appropriate advice.*

In addition, good social skills were necessary for creating networks with others. A comment by a participant from the Central part concerned this issue:

*We need to deal with other professionals and disability organisations. For example, I sometimes ask a social worker to ask for free wheelchairs for disabled people. So, we need to have good social skills for dealing with others.*
10.2.3 Knowledge and Information

Having knowledge about the independent living concept was considered a requirement for occupational therapists. A comment by an academic participant concerned this issue:

*As the independent living concept has never been put into the occupational therapy curriculum in Thailand, it is necessary for the occupational therapy students to know about the concept. We have to teach them in order to enable them to support disabled people to exercise independent living.*

Information relating to independent living was also an important requirement. Some participants talked about information on disability rights. A comment by a participant working in the Central region concerned this issue:

*We need to support disabled people to have equal rights with others. So, we need information about disability rights.*

Some participants reported about Acts and laws. A comment by a participant from the North concerned this issue:

*We deal with disabled people. We need to update our knowledge about acts and laws relating to disability.*

10.2.4 Being Interested in Clients' Contexts

The participants felt that occupational therapists should pay more attention to client's contexts. A comment by a participant working in the Central part concerned this issue:

*We should not do just things that are within our duty. We should not provide solely intervention for disabled people, but we should take an interest in their circumstances as well. For example, we might ask them whether they are registered. Asking them things like this might help them get welfare benefits by being registered as disabled people.*
10.3 Discussion and Summary

In this chapter, participants expressed their opinions on the conceptual models supporting the independent living concept. It also included some requirements for occupational therapists dealing with disabled people who sought an independent life.

10.3.1 Conceptual Models Supporting the Independent Living Concept

According to Kielhofner (2005), to answer the question of what approach best meets the needs of clients, occupational therapy should have to examine how to best balance an emphasis on the needs of the individual versus social change in practice. In this study, three models including the client-centred model, the occupation-based models, and the medical model of disability were reported to support the independent living concept. Regarding to the client-centred model, it was reported to be congruent with the independent living concept especially on the issues of self-direction and consumerism. According to the literature, the client-centred theory has been informed by consumerism and self-help groups that strive to meet needs outside the realm of professional involvement (Sumsion 1999). Furthermore, consumer rights and human rights have also influenced the development of client-centred practice (Sumsion 1999). Client-centred theory was introduced to health care practice by Carl Rogers (1965) in the form of client-centred practice. It is a non-directive approach that is centred on the person's needs (Rogers 1965). It embraces a philosophy of respect for, and partnership with, people receiving services (Rogers 1965). When occupational therapy adopts the concept of client-centred practice, it can be an important step in giving clients voice and control in therapy process (Law 1998). It acknowledges occupational therapy' responsibilities to work in partnership with clients to enable them to find meaning in life through their daily roles, and activities (Law and Baum...
It provides guidelines for practice based on the assumption that service providers can only create an environment that facilitates change, rather than being able to effect change directly (Christiansen and Baum 1997). Therefore, a client-centred practitioner's role is conceptualised as supporting clients through the process of change by providing width and depth of information, ideas, suggestions, resources, through the communication of trust and a belief in the clients' ability to succeed (Christiansen and Baum 1997). When taking a client-centred approach, service providers allow clients to discover their own sources of meaning, accept the client's reports as the most relevant source of information about therapy and bring their resources to the occupational therapy intervention process (Law and Baum 2001). Therefore, the client-centred model is likely to be appropriate for participants to use as a frame of reference for practice providing support for disabled people seeking independence. However, the client-centred model, which originated in Western culture, would need investigation as to whether it can fit with Thai culture before adoption for everyday practice.

The Kawa Model, which is being developed in East Asia, claims to be a client-centred model. This model was developed by Japanese occupational therapists who became frustrated and discouraged from trying to understand and apply imported occupational therapy and rehabilitation theory into their own practice (Iwama 2006a). In this model, life is compared to a river. Life is a complex, profound journey flowing through time and space whilst aspects of the environment and phenomenal circumstances of life are compared to certain structures found in a river such as life circumstances (rocks), environment (walls and bottom), and assets and liabilities (driftwood) (Iwama 2006a). An optimal state of well-being in one's life, or river, can
be figuratively portrayed by an image of strong, deep, unimpeded flow (Iwama 2006a). Through this model, the purpose of service is to enable and enhance life flow by enhancing harmony between all elements that form the overall context. Occupational therapists using this model should recognise the uniqueness of an individual's context, clarify the context, and prioritise issues according to an individual's perspective (Iwama 2006b). The structure and meanings of the river metaphor take shape according to an individual's view of their circumstances in a particular cultural context. Even though Japan, like Thailand, is a collective society that views human occupation as interdependent, it does not mean that Thai occupational therapists can use the Kawa model without investigating whether it is suitable for use in Thailand.

As occupation was reported to be central to occupational therapy practice, occupation-based models were felt to be suitable for use with the independent living concept. However, participants in the study did not mention any particular occupation-based model. Several occupational therapy models can be classified as occupation-based models such as the Canadian Model of Occupational Performance, the Model of Human Occupation, and The Occupational Performance Model. According to Law (2002), participation in life occupations is viewed as a vital part of human development and the lived experience. To improve health and well-being, occupational therapy focuses on enabling clients to participate in everyday occupations that are meaningful for them, provide fulfilment, and engage them in everyday life with others (Law 2002; Wilcock 2005). Normally, people are exposed to different occupations depending on their level of interest, environments, and roles (Law 2002). Hence, using occupation as an occupational therapy intervention enables
occupational therapists to bring clients back to the context of their physical and social world. In addition, it encourages clients to choose what occupations mean to them and also facilitates their participation in all aspects of the occupational therapy service. This is similar to the client-centred model in the emphasis on enhancing choice and control for clients. It seems that the occupation-based models themselves or combined with the client-centred model are harmonious with the independent living concept. They support disabled people to be in charge of their lives and enjoy living in their own context. However, it is necessary to conduct further investigations to find out whether these existing models are suitable for use as a frame of reference for practice in supporting independent living in Thailand.

Even though participants valued the client-centred and the occupation-based models as a frame of reference for practice that enabled them to provide appropriate support to disabled people seeking independence, they thought that the medical model still had its own importance particularly for clients who were in the acute stage. In both Western and Asian countries, health services are primarily organised according to the medical model, where illness and impairment are viewed as conditions of the body in which the structure or function of the body is disturbed or impaired (Lee and McCormick 2002). Based on the medical model, it is stated that “the medical and rehabilitation services are directed towards the application of treatments that might enable individuals to overcome their functional deficits and appear in a manner that is as near to normal as possible” (Hammell 2006: pp 58). However, it is difficult to see how an individual’s aspirations for community living can be realised following the medical model. It is deemed neglectful of the extent to which restriction of activity or social disadvantage that an individual confronts in his or her everyday life can be
attributed to social oppression (Williams 2001). Therefore, the medical model of
disability was recommended for some usefulness in informing intervention for clients
in the acute phrase who needed acute and restorative care. However, the medical
model could not support disabled people to live independently in the community. This
seemed to signal a favourable prospect for promoting independent living in Thailand
because participants realised the importance of social inclusion for disabled people
and the limitations of the medical model of disability.

10.3.2 Requirements for Occupational Therapists

Participants reported that there were some requirements for occupational therapists
involved with disabled people engaging in independent living. These requirements
included ‘working in the community’, ‘counselling and social skills’, ‘knowledge
about the independent living concept and information relating to independent living’,
and ‘being interested in disabled people’s contexts’.

In this study, it was evident that a major shift to community-based practice was
required in order to enable disabled people to be independent. The participants’
reports were in line with the Thai government’s attempt to provide free health care
services to cover all disabled people in the community (Office of the National
Economic and Social Development Board 2006a). According to McColl (1998), the
inevitability of a transition to community practice of occupational therapists has been
mentioned for three decades. This shift was encouraged by trends in health promotion,
disease prevention, cost-effectiveness, legislation, and political movements (Grady
1995). In addition, the independent living model is one of three models of community
services encouraging health professionals to create their new roles in the community
(McColl 1998). It is stated that the rise of the independent living model challenges health professionals to work with disabled people to develop appropriate practice based upon the social model of disability (Oliver 1999). Therefore, if occupational therapists in Thailand still provide their services only in a clinical setting rather than providing services in the community, it seems impossible for Thai disabled people to fully enjoy their lives in the community. This is because the functional limitations of disabled people remain the central focus and also disabled people's contexts are not taken into account in occupational therapy interventions without reaching out to the community.

Apart from working in the community, participants also reported that counselling and social skills were required in order to enable them to provide appropriate support to disabled people seeking independence. Counselling skills enabled them to communicate with disabled people and their family members appropriately whilst social skills were regarded as enabling them to cooperate and collaborate with other professionals. It is a fact that disabled people face significant needs in education, daily living, healthcare, and employment, etc. Because of these needs, disabled people require services from occupational therapists and other professionals. Having counselling skills would enable occupational therapists to improve their provision of services. Having social skills would enable occupational therapists to work as a team with other professionals which would result in effective services and clear goals for disabled people. Lemorie and Paul (2001) also found that professional expertise in community-based occupational therapists was essential. They found that communication and interpersonal skills were emphasised as very important for
effective interaction of health care teams and maintaining client involvement in the community.

In addition, participants in the study reported that knowledge about the independent living concept was necessary for occupational therapists involved with disabled people seeking independence. In Thailand, the independent living concept is recognised by few people even though the concept was introduced to Thailand more than two decades ago. Furthermore, health professionals have limited knowledge of the independent living concepts (Oka 1988). This might be because the independent living concept has never been included in the occupational therapy curriculum. Only some participants that studied or had work experience in other countries were familiar with the concept. Therefore, the results of this study indicate the importance of promoting an understanding of the independent living concept. In addition, occupational therapists also needed information relating to independent living such as empowerment, self-determination, rights, advocacy, consumer control, removal of social barriers, and political activism in order to enable them to provide assistance to disabled people in the form of guidance, counselling, equipment and aids. All of these require development of a knowledge base that is considerably beyond what most occupational therapy students are currently offered (McColl 1998). An example was the integration of disability studies concepts into occupational therapy education (Block et al. 2005; Gitlow and Flecky 2005). This innovation was viewed as enabling occupational therapy students to appreciate and understand about disability as an individual, environmental, and societal construct (Block et al. 2005; Gitlow and Flecky 2005). As the independent living concept had never been taught in Thai occupational therapy curriculum, it is also necessary for Thai occupational therapy
students to understand about the concept of independent living along with the new course of disability studies in order to enable them to have greater awareness of the experience of disable people, and to contribute to social change towards independent living for disable people in Thailand. It is stated in the second and third National Plans of Quality of Life Development (Office of Empowerment for Persons with Disabilities 2007; Office of the National Economic and Social Development Board 2006a) that the personnel involved required education and development in order to enable them to provide services to meet the needs of disabled people. This seemed to be a great opportunity for participants to increase their own proficiency in order to enable them to serve the needs of disabled people in the community (see Chapter 3; 3.1.5.1).

Being interested in clients' contexts was also reported as a requirement for occupational therapists. As mentioned in the above paragraph, independent living is a complex issue involving many aspects of disability. Hence, to ensure that all the needs of disabled people are addressed, widening the span of attention to include disabled peoples' contexts seems to be inescapable for occupational therapists concerned with independent living.

In conclusion, this chapter presented and discussed suitable models for occupational therapists to use with the independent living concept and their requirements to be able to use the models. The results of the study indicated that two types of models, the client-centred and occupation-based models, were congruent with the independent living concept. They were appropriate for occupational therapists to use as a frame of reference for practice because they enabled them to take a supporting role and also
enabled disabled people to have control over their lives in their real world. To enable occupational therapists to work with disabled people seeking independent living, ‘community based practice’, ‘counselling and social skills’, ‘knowledge about independent living and information relating to independent living’, and ‘being interested in clients’ contexts’ were felt to be necessary for occupational therapists.
Chapter 11

Conclusion

Participants' views relating to independent living were presented and discussed in Chapter 6 to Chapter 10. This chapter summarises the findings of the study. Furthermore, the implications of the findings, the limitation of the research as well as future research are discussed.

11.1 Summary of Findings

This study aimed to investigate the understanding and beliefs about independent living in Thai occupational therapists. It also explored their opinions on the feasibility of independent living for physically disabled people. In addition, models judged appropriate and strategy for practice for Thai occupational therapists to use were identified. With focus groups and individual interviews, 26 occupational therapists involved with physically disabled people were interviewed. The findings of the study are summarised below.

11.1.1 Understanding and Beliefs about Independent Living

This study showed that all participants acknowledged the significance and importance of independent living. This indicated that independent living concerning autonomy and participation had been integrated with values shared by the participants. However, it was evident that some participants did not have an understanding of the basic philosophy of independent living regarding self-determination (Crewe 1979; Evans 2002a; Morris 1993). Therefore, the notion of control seemed in need of promotion
among Thai occupational therapists. According to their construction of professional responsibilities, it was crucial that they enter their clients' world in order to provide support for independent living. Participants expressed their feelings about independence both positive and negative. Even though they felt that it was difficult to change the attitude of Thai disabled people from being dependent to being independent, their positive feelings outweighed their negative feelings. Participants understood the degree of independence based on the knowledge of human rights as promoted in individualistic cultures. However, the influence of collectivism regarding social connection and dependence on others on participants' opinions was found. Therefore, it is necessary to consider cultural differences when implementing the notion of independent living because it originated from an individualistic culture rather than a collectivistic culture, as found in Thailand.

11.1.2 The Feasibility of Independent Living in Thailand

It was an argument among participants regarding the feasibility of independent living in Thailand. Some occupational therapists felt that independent living for Thai disabled people was feasible because of the emerging changes in family structure from an extended family to a nuclear family and the higher level of education of people. On the other hand, participants reported that independent living for disabled people in Thailand was difficult and needed a period of time during which barriers existing in the Thai context would need to be addressed. Six factors or contexts where there were barriers were described when discussing the feasibility of independent living for disabled people in Thailand. These were 'disabled people themselves', 'family', 'people in the community', 'finance', 'the physical environment', and 'the initiatives of the Thai government'. With respect to disabled people, family, and
people in the community, the study showed that attitudes towards disability were problematic. Being unable to accept their disabilities and having unrealistic hope were reported to be a typical pattern among disabled people. They depended on their family members. It was also difficult for Thai disabled people to be active consumers. Whilst rejection and overprotection were found in family members, negative attitudes towards disabled people were reported in people in the community. According to Groce (1999), the way societies treat disabled people is based in part on culturally-based beliefs about why a disability occurs. Most Thai people are Buddhist. In Buddhism, disability is viewed as a product of karmic retribution and consequently disabled people are viewed with pity and are incapable people who should receive help rather than being capable in the social world (Viboolpholprasert et al. 1997). These beliefs affected the attitudes of disabled people towards themselves because these beliefs have made it difficult for disabled people to achieve equality of esteem or be motivated to overcome disability and handicap. Disabled people in Thailand normally think that they should receive help from others rather than be self-reliant. These beliefs about disabled people are also held by family members and people in the community with the result that disabled people have limited opportunities to assert their rights in ways promoted by the independent living concept. Therefore, the results of the study have indicated that attitudes towards disability by disabled people, their families, and people in the community need to be changed.

In addition, another result of the study highlighted the importance of financial support as an area or factor that enabled disabled people would need to take control over decisions and their lives. Financial constraints had negative impacts on self-autonomy and family relationships. Hence, financial constraints faced by disabled
people in Thailand needed to be addressed. Furthermore, physical barriers were reported to be found everywhere both in disabled people’s dwellings and in the community. These barriers prevented disabled people from enjoying life in the community. There was concern that if physical barriers were not given attention, independent living for disabled people in Thailand would be impossible. At the time of the interview period of the study it was reported that the Rehabilitation of Disabled Persons Act needed to be revised. The government’s plans were ineffective and dissemination of the disability strategies was poor. Although the Thai government had tried to address some of these problems, there remained many that needed to be resolved. In 2007, the Thai government promulgated new disability legislation called the Act on Promotion and Development of Life Quality of Persons with Disabilities A.D. 2007 instead of the Rehabilitation of Disabled Persons Act. This new Act focused on anti-discrimination and stronger employment promotion measures. Even though the 2007 Act was developed from lessons learnt from the Rehabilitation of Disabled Persons Act, at the time of the research it was too early to assess its effectiveness as a mechanism for promoting independent living for disabled people in Thailand.

11.1.3 Support from Occupational Therapists

The findings of this study showed that the first step for Thailand to enable disabled people to engage in independent living was the promotion of fuller understanding about disability and the concept of independent living relating to self-direction, self-advocacy, self-help, peer service provision, consumerism, and rights. There were social barriers encountered by disabled people, among family members, people in the community, and health professionals. Many strategies were suggested for promoting
an understanding about disability and the independent living concept. Some of these strategies could be pursued by occupational therapists but others required cooperation and collaboration with other stakeholders including disabled people, their families, key people in the community, disable peoples' organisations, other professionals concerned with disability, and the Thai government. Figure 11.1 illustrates the key stakeholders whose cooperation and collaboration would be needed in order to support independent living. A summary of practice guidelines for Thai occupational therapists for supporting independent living for disabled people is shown in Table 11.1.
Figure 11.1 Diagram of cooperation and collaboration among key stakeholders in order to support independent living for disabled people in Thailand
Table 11.1 Summary of strategies for practice for Thai occupational therapists to use for supporting independent living for disabled people

<table>
<thead>
<tr>
<th>Aims of independent living</th>
<th>Strategies</th>
<th>Methods</th>
</tr>
</thead>
</table>
| Self-direction             | Promotion an understanding about disability in disabled people and their family | • Counselling: informal and formal forms  
• Peer support and role model  
• Published and visualised media                                                                 |
|                            | Promoting self-directed skill                                               | • Supporting disabled people to find their needs  
• Supporting disabled people to establish and achieve their goals since in the hospital by the use of discussion group  
• Supporting disabled people to achieve their goals both in the hospital and in the community by the use of simulation, going into the community, the use of role model in the real environment, and providing an advanced training program |
| Self-advocacy             | Promoting an understanding about advocacy                                   | • Role model                                                            |
|                            | Supporting disabled people to advocate their rights                         | • Providing information about available sources in the community  
• Having network and cooperating with others                                                      |
Table 11.1 Summary of strategies for practice for Thai occupational therapists to use for supporting independent living for disabled people (continued)

<table>
<thead>
<tr>
<th>Aims of independent living</th>
<th>Strategies</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help</td>
<td>Promoting the concept of self-reliance</td>
<td>• Providing information about existing disability groups</td>
</tr>
<tr>
<td></td>
<td>Encouraging disabled people to act as a group</td>
<td>• Setting up a new group</td>
</tr>
<tr>
<td></td>
<td>Maintaining support</td>
<td>• Supporting group activity by providing encouragement, guidelines and advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthening groups by providing knowledge to members of groups and networking with other self-help groups</td>
</tr>
<tr>
<td>Peer service provision</td>
<td>Providing disabled people with an opportunity to meet their peers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Looking for peer counsellors and providing information for their use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Providing information about resources available in the community</td>
<td></td>
</tr>
</tbody>
</table>
Table 11.1 Summary of strategies for practice for Thai occupational therapists to use for supporting independent living for disabled people (continued)

<table>
<thead>
<tr>
<th>Aims of independent living</th>
<th>Strategies</th>
<th>Methods</th>
</tr>
</thead>
</table>
| Consumerism                | Promoting an understanding about the consumerism concept in health professionals | • Providing verbal information  
                              | Promoting an understanding about the consumerism concept in disabled people | • Print media and audio-visual media  
                              | Providing support to encourage disabled people to take a consumer role | • Their peers  
                              |                                                                                       | • Changing the perception of occupational therapists towards disabled people by viewing them as clients who should control the services provided, and viewing the disabled person as an expert who knows what is best for his/her own life  
                              |                                                                                       | • Providing enough information on which to base choices and allowing disabled people to choose  
                              |                                                                                       | • Allowing disabled people to provide feedback |
Table 11.1 Summary of strategies for practice for Thai occupational therapists to use for supporting independent living for disabled people (continued)

<table>
<thead>
<tr>
<th>Aims of independent living</th>
<th>Strategies</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal rights</td>
<td>Promoting an understanding about disability rights in disabled people and their families</td>
<td>• Providing information by occupational therapists and their peers in disability groups</td>
</tr>
</tbody>
</table>
|                            | Providing support to disabled people to assert their rights | • Encouraging disabled people to have a sense of equality  
• Preparing disabled people to be ready for asserting their rights  
• Providing disabled people with information about resources available in the community  
• Cooperating with others, e.g. other health professionals, heads of communities, and disabled peoples’ organisations |
| Changing social attitudes  | Promoting an understanding about disability in people in the community | • Visual media  
• Outreach services  
• Providing direct experience to the younger generation |
|                            | Building positive attitudes towards disabled people | • Community based rehabilitation (CBR)  
• Encouraging disabled people to show how capable they can be |
<table>
<thead>
<tr>
<th>Aims of independent living</th>
<th>Strategies</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removing physical barriers</td>
<td>Ensuring cooperation between professionals involved with accessibility</td>
<td>- Environment adaptation in disabled peoples’ dwellings and in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistive devices</td>
</tr>
<tr>
<td>Providing support for disabled people to go into the community</td>
<td></td>
<td>- Encouraging disabled people to insist on improved legislation requiring accessibility through representatives of disabled peoples’ organisations</td>
</tr>
<tr>
<td>Providing support for disability groups to call for accessibility</td>
<td></td>
<td>- Encouraging disabled people, through disabled peoples’ organisations, to call for a monitoring system backed by penalties for laws concerning accessibility</td>
</tr>
</tbody>
</table>
11.1.4 A Conceptual Model Supporting Independent Living & Requirements for Occupational Therapists

In this study, the results indicated that the client-centred and occupation-based models were a basis for a frame of reference for practice to support of independent living. They were appropriate for occupational therapists to use as a frame of reference for practice because both models emphasis encouraging disabled people to enhance choice and control. With such encouragement, disabled people would choose what occupations would be meaningful for them in their own physical and social environments. In addition, disabled people would be provided with opportunities to participate in all aspects of the occupational therapy service. To enable occupational therapists to provide support for disabled people seeking independent living, 'community based practice', 'counselling and social skills', 'knowledge about independent living and information relating to independent living', and 'being interested in clients' contexts' were highlighted as basic requirements.

11.2 Implications of the Findings

Based on the findings, this section presents the implications of the study for practice, policy, education and research.

11.2.1 Implication for Practice

This section concerns the implication of the findings at the practice level. It includes the issue of promoting independent living in Thailand, and support from occupational therapists.
11.2.1.1 Promoting Independent Living in Thailand

The results of this study indicated that it seemed possible for disabled people to become more independent because of the changes occurring in Thai culture. However, the study highlighted the influence of collectivistic culture on the way of life of Thai people. From the participants' point of view, 'social connection', 'dependence among people', 'respecting other people' and 'not breaking the law' were restraints on the degree of independence. Whilst the independent living movement originally encouraged disabled people to have full control over their lives and their decisions, the degree of independence in Thailand was thought to be restrained by social connection and dependence on others. It might be difficult to encourage disabled people in Thailand to have the full autonomy promoted by the independent living movement. Rather than having fully control over their lives like disabled people in the West, it seems that disabled people in Thailand could only expect some degree of control over their lives. Therefore, when implementing the independent living concept in Thailand, cultural differences may place some restraints on expectations based on the original construction. The independent living concept in Thailand may not be implemented to the same extent as in an individualistic or Western culture. Alternatively, to promote independent living for disabled people in Thailand, the community perspective of independent living suggested by Woodill (2006) focusing partnerships and relationship among people or living inter-dependently suggested by Takamine (1998) and Werner (1998) might be more suitable than the original independent living concept promoted in developed countries.

Even though it seemed possible for disabled people to become more independent because of the changes occurring in Thai culture, it was clear from the comments of
the participants that much needed to be done to facilitate independent living. Actions
needed to target disabled people, their families, people in the community, financial
resources, the physical environment, and the Thai government. The following
paragraphs present the implementation of the study at the practical level through
disabled people, their family, people in the community and the Thai government
whilst the rest will be presented at the policy level.

**Disabled people**

Disabled people in Thailand were found to lack an understanding about disability
which could result in them having an unrealistic hope. They also were dependent on
their family members. As a result of cultural beliefs affecting their attitudes towards
themselves, much education needs to be undertaken with disabled people themselves
and discordant cultural beliefs need to be challenged to further develop independent
living. It is stated that “culture is passed down from generation to generation through
it is learned and that culture is adaptive and integrated” (Loveland 1999: pp. 23).
Therefore, educating disabled people in the community about impairments and how to
live with disability might enable them to have a positive attitude towards disability
and change their understanding of disability. They also should be aware of their rights
and how to engage in advocacy. Without awareness and advocacy they will not be
able to take control of their lives and decisions on issues relating to them. At the same
time, information and resources to assist them in optimising their existing capacities,
identifying and obtaining suitable assistive devices, making environmental
adaptations, and accessing services are very important in empowering people to
maximise their independence.
**Family**

Participants reported that family attitudes towards disabled people had an impact on the feasibility of independent living. Over-protectiveness and doing everything for disabled people limited opportunities for disabled people to take control of their lives. But rejection and providing less support resulted in disabled people not receiving good care. In contrast, acceptance and providing appropriate support were recognised as enabling disabled people to live independently. Therefore, success with independent living is dependent on understanding and support in families.

In the family context, firstly family members need to understand how disabled people are able to live productive lives with their impairments. Secondly, the positive power of the family should be acknowledged and harnessed. Providing families with information, role models, and encouragement, enables families to provide disabled people with appropriate support, assistance, and opportunities to be in charge of their lives and enjoy their lives in the community. Thirdly, to reduce the burden of assisting their loved ones, it is also necessary to provide family members with information on options which can allow disabled people to be independent such as assistive devices, environmental adaptations, and personal assistants.

**People in the Community**

Participants acknowledged that being accepted by people in the community would provide disabled people with opportunities to exert their rights equals. Participants also reported that attitudes of people in the community towards disabled people varied from positive attitudes to negative attitudes. To build an atmosphere of living together in the community between non-disabled people and disabled people, the negative
attitudes of people need to be addressed and the potential of non-disabled people to provide support should be better acknowledged and promoted. Additionally, educating people in the community about impairments and how to give appropriate assistance to disabled people might enable them to accept disabled people and welcome them into the community. Furthermore, it is necessary to familiarise the community with the requirements and contributions of disabled people. These strategies would provide opportunities for community participation and asserting the rights of the disabled.

**the Thai Government**

Even though the government had tried to continuously improve its work on disability, its effort was not recognised by people involved with disability. Similarly, the government’s national plans on disability were not well-known among people who needed to support disabled people to be independent. All of these problems indicate that information about disability is not effectively disseminated. Therefore, the Thai government should improve its distribution of information about disability in order to enable people related to disability to have a clear understanding about the work and plans that the government is providing. As there appeared to be no outcomes specified in the national plan on disability, the Thai government should make disability a high priority and also have outcome indicators in place and make a principal organisation take responsibility for particular components of strategy. These measures might ensure that the government completes work components as detailed in its plan and within the stipulated timeframe. Occupational therapists might work with DPI-Thailand on outcome indicators for legislation.
11.2.1.2 Support from Occupational Therapists

From participants' reports, occupational therapy involved with disabled people seeking independent living needed to take a supportive role. The client-centred and occupation-based models were a basis for a framework of practice to support independent living. The results of the study showed it was essential for occupational therapists to widen the focus of practice beyond narrow concern with the services being provided by individual centres and assist their clients through community based practice. However, due to a small number of occupational therapists, occupational therapists normally spend most of their working hours providing services to clients in institutional settings. Additionally, participants in the study reported that they did not have much time to deal with their clients due to the shorter lengths of stay in hospitals and the quick return of clients to the community. Therefore, to enable them to work in the community and provide full support to disabled people, changes need to be made to their workloads and schedules. Such changes would have to promote the importance of providing services in the community in spite of the problems created for their hospital directors and a doctor who is the head of rehabilitation team in order to provide services out in the community.

Counselling and social skills, knowledge about independent living and information relating to independent living, and being interested in clients' contexts were also regarded as necessary for occupational therapists involved with disabled people exercising independent living. Whilst skills might be gained from training and practice, knowledge about independent living and information relating to independent living was gained from the researcher. Alternatively, disability organisations, and the internet are other resources for knowledge and information.
To promote independent living for disabled people in Thailand, the participants suggested many strategies and methods to promote self-direction, self-advocacy, self-help, peer support provision, consumerism, equal rights, and removing social barriers. Participants themselves could accomplish some of these strategies but some strategies required cooperation and collaboration from all stakeholders including the individual level (disabled people themselves), their families, people in the community, organisations concerned with disability, other professionals concerned with disability, and the levels of government. To enable the research be of maximum benefit, strategies for practice based on participants’ understandings should be introduced to other occupational therapists to fully discuss the strategies for practice. Then, strategies for practice should be opened for an intensive discuss by other stakeholders mentioned above about how these strategies would be implemented.

11.2.2 Implication for Policy

To promote independent living for disabled people in Thailand, it was evident that some issues relating to disabled people required change at the policy level. These issues included finance, physical barriers.

It was evident that having financial support provided disabled people with opportunities to take control over decisions and their lives whilst financial restriction had negative impacts on self-autonomy and family relationships. Even though the Thai government provided some financial support, participants felt that the amount was insufficient. Employment is one way to ensure that disabled people achieve financial security. Therefore, it is necessary to for the Thai government to recruit
cooperation and enhance communication between the Thai government, organisations and people in the community to increase work opportunities for disabled people. Alternatively, the Thai government may need to provide the unemployed disabled with more financial support.

Pertaining to physical barriers, the result of this study revealed that physical barriers prevented disabled people from enjoying their lives in the community. To overcome physical barriers, it is necessary to empower disabled people to use collective action as highlighted in the philosophy of independent living to request accessibility according to Acts and laws in Thailand. In addition, the Thai government will have to enforce the existing guidelines on physical barriers in public places as determined in its Act and laws. Disability organisations should work towards systems change in order to create more accessible communities. Health professionals can also be active advocates within systems and facilitate system change by educating individuals about rights and providing training in self-advocacy skills.

11.2.3 Implication for Education

Even though all participants seemed to acknowledge the significance of independent living, it was evident that education about the notion of control would be of benefit for some participants. This could be done by giving presentations about the research to all participants. Giving presentations to all participants who dedicated their time to the study would succeed in promoting the notion of control in participants who defined independence as physical ability, without singling them out in any way. More generally, when considering occupational therapists’ responsibilities, the result of the study indicated that it was crucial to enter client’s world to provide support for
independent living. As a consequence of this, it seems appropriate for the research to be introduced to occupational therapists more widely in order to give them a fuller understanding of the independent living concept – an understanding of promoting autonomy and participation for disabled people in accordance with the Thai government legislation.

Some participants noted that the independent living concept has not been included in the occupational therapy curriculum. Thus, the researcher who is involved in the educational sector of occupational therapy has a responsibility to propose the independent living concept and relative issues such as disability studies to schools of occupational therapy. This would enable occupational therapy students to obtain knowledge and understanding about disability and the independent living concept and consequently enable them to provide appropriate support for disabled people exerting independent living. In addition, to ensure that occupational therapy education could serve the need of disabled people in Thailand, occupational therapy curriculum should be sent to DPI-Thailand to evaluate whenever occupational therapy curriculum is revised.

11.2.4 Implication for Research

The findings of this study revealed that there was an influence of collectivistic culture on the way of life of Thai people. Therefore, it is necessary to operate the philosophy of independent living generated from Western culture in emancipatory research. In addition, as participants proposed strategies for practice to support independent living for disabled people in Thailand, it is also necessary to test strategies for practice to ensure that they are appropriate and practical for use in Thailand to support
independent living. This might be conducted in the form of multidisciplinary and emancipatory research. Furthermore, the finding indicated that the client-centred and occupation-based models were a basis for a framework of occupational therapy practice to support independent living. It would be important to have other occupational therapists discuss and evaluate whether both models would be able to support independent living for disabled people in Thailand.

11.3 Limitations of the Research and Directions for Future Research

Although the focus groups and interviews gathered valuable insights from the participants, limitations of this research must be borne in mind, and directions for future research pointed out.

The information in this study was gathered from only 26 occupational therapists from four different geographic areas. These finding may not be representative of all occupational therapists in Thailand. However, there were consistencies in the opinion of the participants which assists us in understanding their perspectives on the independent living issue. This study investigated the understandings of occupational therapists involved with physically disabled people. Therefore it may not reflect the views of occupational therapists involved with people having other disabilities. Since participants volunteered to be involved in this study, it is likely that they were more self-determined than other occupational therapists that did not volunteer and so the understandings elicited may not be representative of a broader group. It should be noted that, although there were participants from the South and North-East of Thailand, they were occupational therapists who worked in the same provinces. Consequently, they cannot be considered as representative of occupational therapists
scattered across both those areas of Thailand. As the study was designed to be a qualitative research, bias and the lack of verification is general. Qualitative research is often seen as less rigorous than quantitative method. To solve this, the researcher’s own stance has been described as qualitative research is interpretive in nature. The reader is encouraged to reflect on whether that particular stance led to overlooking or paying too much attention to particular insights based on the focus group and interview data.

To go beyond the present study, a larger study should be undertaken with group moderators representing a variety of stances, and as many occupational therapists as possible, who work with physically disabled people throughout Thailand on independent living. This would provide a broader basis for understanding how support should be provided for people with acquired physical impairments and elaborating on the frame of reference for practice emerging from this research. Understandings of occupational therapists involved with people having other disabilities could then be investigated in order to bring together insights into the full range of issues related to independent living. This research highlighted some of the potential differences between the Thai and Western notion of independence. An in-depth exploration of the similarities and differences of this concept across cultures was beyond the scope of this study and warrants parallel investigations in other countries. Future comparative research could help evaluate the effectiveness of measures adopted to promote independent living.
11.4 Final Conclusion

This study explored the understandings and beliefs of occupational therapists in Thailand concerning the issue of independent living. With focus groups and individual interviews, 26 participants provided information for the research. The results of the study indicated in what ways disabled people in Thailand could exercise independent living even though it seemed to be difficult for Thai disabled people to assert independence. The research affirmed the suitability of officially implementing the independent living concept in Thailand and indicated how to secure its benefits for disabled people through cooperation and collaboration between multiple levels of Thai society.

Some similarities and differences between the independent living concept in the West and the independent living in Thai’s perspectives were identified in the study. Whilst financial limitations and social barriers were a common problem that disabled people throughout the world had to confront, the influence of a collectivistic culture regarding social connection, interdependence, the degree of independence, and the view of disability were different. Whilst social connection and interdependence prevented disabled people from achieving autonomy, viewing disability affected the attitudes of disabled people, their families, and people in the community towards disability and also affected the provision of support to disabled people. These beliefs do not fit with the theoretical view of independent living in the West and may cause independent living in Thailand to be different, particularly in an aspect of autonomy. Whilst the issue of attitudes towards disability might be addressed through providing knowledge and information about disability and the independent living concept, the influence of collectivistic culture seems to be difficult to overcome. Perhaps, the
community perspective of independent living or living interdependently might be more suitable than the original independent living generated in the Western culture.

In addition, consumerism is an aspect of independent living that may be difficult for Thai disabled people to achieve since the typical Thai character does not support them to be active consumers and financial limitation does not allow them to be in the position of purchaser who can choose what they want. However, all aspects of independent living including self-direction, self-advocacy, self-help, peer service provision, consumerism, equal rights and removing social barriers should be promoted in disabled people in Thailand as a whole package. Strategies and methods for encouraging and empowering disabled people may vary in each country depending on the country’s context.

This research explored the opinion of occupational therapy about independent living for physical disabled people in Thailand. When making the new knowledge arising from the research to be explicit, it should be implemented first in the group of physically disabled people. The independent living concept should be implemented simultaneously throughout the country. To do this, DPI-Thailand should take a principal role in implementing the independent living concept whilst cooperation, collaboration, and support could be obtained from disability professionals. The Thai government should take primary responsibility and ensure its systems are ready to support independent living for disabled people. Firstly, DPI-Thailand should develop guidelines for implementing the independent living concept from lessons learnt from the first training program in 2002. DPI-Thailand should then distribute these guidelines to potential disability organisations in order to enable them to implement
the independent living concept in their areas of responsibility. Disability organisations should then promote the independent living concept to disabled people who are listed in their databases. Through encouragement, knowledge and support, disabled people who seek to live independently would be empowered. Also, their families and people in the community should be encouraged to see the importance of the independent living concept and how they could provide appropriate support to disabled people.

The outcome of the project should be assessed regularly. Strong disability organisations should provide assistance and support to other disability organisations in order to strengthen them through a system of peer support. Similarly, disabled people who can live independently should be role models for other disabled people in order to encourage them to be active members of society. Through cooperation and collaboration at multiple levels of society, independent living for disabled people throughout Thailand could be a reality as declared in the national plans of the Thai government.


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Appendice
Appendix 1

Initial Questionnaire

1. Given name............................................Family name............................................

2. Qualifications
   [ ] Bachelor of Sciences (Occupational Therapy)
      The year of graduation.................................................................
   [ ] Post graduate course (Please specify)...........................................
      Educational institution.................................................................
      The year of graduation.................................................................

3. How long have you worked as an occupational therapist?..................

4. Address of your current workplace.................................................
    .....................................................................................................Tel..............................

5. What is the type of your current workplace?
   [ ] Hospital attached with university
   [ ] Regional hospital
   [ ] General hospital
   [ ] District hospital
   [ ] Private hospital
   [ ] Others (Please specify)..................................................................

6. Have you had experience working in other workplaces?
   [ ] Yes (Please specify).................................................................
   [ ] No

7. What was the type of your previous workplace?
   [ ] Hospital attached with university
   [ ] Regional hospital
   [ ] General hospital
   [ ] District hospital
   [ ] Private hospital
   [ ] Others (Please specify)..................................................................

8. What type of impairment of disabled people does your current work involve with?
   [ ] Impairment in terms of physical functioning and locomotion
   [ ] Impairment in terms of intellectual and learning ability
   [ ] Impairment in terms of mentality and behaviour
   [ ] Impairment in terms of sight
   [ ] Impairment in terms of hearing and communication

9. Please rank these groups of clients according to the level of your involvement from most-1, fair-2, least- 3)
   [ ] Children    [ ] Adults    [ ] Elderly

10. Have you experienced working in the community?
    [ ] Yes
    [ ] No
Appendix 2

Participant Information Sheet

TITLE: Independent Living: models and guidelines for practice for Thai occupational therapists

INVESTIGATOR(S): Mrs Jananya Dhippayom

Doctor of Philosophy Student
The Department of Occupational Therapy
School of Healthcare Studies
Cardiff University
UK

Dr. Gail Boniface

Project Supervisor
The Department of Occupational Therapy
School of Healthcare Studies
Cardiff University

Dr. Wynford Bellin

Project Supervisor
School of Social Sciences
Cardiff University

The researcher would like to invite you to provide information to the research. To enable you to feel free in participating in the research, could you please read this information before making a decision. You can ask for more information or discuss with the researcher if you require.
This research will explore occupational therapists' opinions on independent living with four specific aims. The first aim is to understand what independent living means to Thai occupational therapists. Secondly, the research seeks to know whether independent living for people with physical impairments in Thailand is feasible. Thirdly, the research aims to identify what support should be offered in order to enable people with physical impairments in Thailand to engage independent living. Lastly, the research aims to identify models of practices giving support to independent living. The anticipated outcomes of the research are to have models and guidelines for practice for Thai occupational therapists to use for supporting people with physical impairments to be independence as determined in the National Plan of Quality of Life of the Thai government in the year 2002 to 2007.

To accomplish these aims, the researcher would like to invite approximately 20 occupational therapists to give information to the research. Occupational therapists having at least 4 years working experience and being involved with people with physical impairments are required. With focus group, occupational therapists participating in this research will have an opportunity to express and share their experiences on the issues that the researcher provides.

Before conducting focus groups, the researcher will send you information about independent living in order to enable you to think about it. The researcher will conduct focus groups in the same geographic areas with your workplace. For your convenience and safe, the researcher will arrange locations for focus groups. The researcher also takes responsibility on organising convenient date and time with you and other participants working in the same geographic area with you. To enable you
to fully express your opinions, each focus group will be reconvened. Each focus group will take one to two hours depending on how much you want to say. In order to enable you to check and express more opinions, information from the first focus group will be analysed, summarised, and informed you in the second focus group.

You can freely decide whether you want to participate in the study or not. In case you want to participate, a consent form will be given to you before focus groups start. You are free to withdraw from the project at any stage without penalty.

While there may be no direct benefit to you from participating in the study, your thoughts and experiences may help Thai occupational therapists to have appropriate models and guidelines to use for supporting disabled people in Thailand engaging independent living. There are also no risks involved in participating in this study. The researcher will take responsibility on all expenses incurred from participating in this project. To prevent any discomfort you may feel in focus groups, the researcher will conduct focus groups carefully.

Your privacy while participating in the study will be maintained at all times. To protect your identity, a pseudonym (alternative name) will be used in all reporting and publication of information. A tape recording machine will be used to record the interview. The data will be fully transcribed word-by-word and sent to you to review by post. The data will be kept in a secure location and will not be discussed outside the research team. Audiotapes will be erased at the end of the study and typed transcripts will be kept in the personal computer of the researcher.
When the study finishes, a report on the completed study will be reported to the Occupational Therapist Association of Thailand. In addition, to achieve the maximum benefit for occupational therapists and disabled people in Thailand, the completed study will be submitted for publication into a relevant journal.

Should you have any questions regarding the research, please feel free to contact Mrs. Jananya Dhippayom on 3233 7963 (Thailand) or j_panyamee@hotmail.com. She will be happy to provide you with more information. If you are interested in receiving feedback on this study after it is completed, you can contact Mrs Jananya Dhippayom directly about this.

This study is a PhD research of the researcher who is studying at Cardiff University, UK. This study has been cleared by the human ethics committees of Faculty of Associated Medical Sciences, Chiang Mai University, Chiang Mai. You are free to discuss your participation in this study with the project supervisors, Dr. Gail Boniface, on +44 (0) 29 2074 3713 or Boniface@cf.ac.uk and Dr. Wynford Bellin, on +44 (0) 29 2087 5390 or Bellin@cf.ac.uk.

Thank you for your interest in this research project.

Note: This document was translated into Thai
Appendix 3

Information of IL

Independent Living (IL)

I could not see why I should spend hours trying to do something that was physically draining and exhausting when someone else could do it in five minutes ... I have very limited energy and resources. Why should I waste them? .... The most important thing to me was to spend all of my energy in developing a relationship with my son.

(Lawrence 1989, P. 773)

What is Independent Living?

Independent living refers to a way of life that allows people with disabilities to take control of their lives and to participate actively in day-to-day life in the community.

What does Independent Living Emphasise?

- removing social barriers
- promoting civil rights
- self-help
- self-direction
- peer service provision
- self-advocacy
- consumer control
**Background of Independent Living**

The concept of independent living originated in the United States of America (USA) in 1960s. The philosophy behind independent living promotes individual power and a belief in a person’s ability to make decisions and take actions that affect the course of his or her life. It is associated with the concepts of freedom, self-determination, and individual autonomy. The impetus for the independent living movement came from people with disabilities and the organisations they created.

**Movements Related to Independent Living**

The independent living concept is based on the social model of disability and rests on several assumptions. The social model of disability states that disability is socially constructed and is caused by socially and physically disabling environments rather than being the result of individual impairments. According to the social model of disability, people are disabled when they are viewed by society as a minority group and, consequently, are devalued and discriminated against. In order to reduce the disabling impact of society, the social and physical barriers in societies’ resources need to be removed. Furthermore, the social model proposes that people with disabilities have the right to and responsibility for control over their own lives. In addition to being framed by a social model of disability, the independent living movement was influenced by other complementary social movements which included civil rights, consumerism, self-help, demedicalisation, and deinstitutionalisation.
Independent Living: Thai’s Perspectives

The researcher used to explore the perspectives of 13 Thai people with acquired physical disabilities on independent living and the barriers and supports to independent living in Thailand. Summary of their life experiences and perspectives were shown below.

Most participants were satisfied with their current lives once they had adapted to their impairments. They could do things for themselves and participate in the workforce. On the other hand, a few participants were not happy because of longing to be ‘normal’, uncertain health, and seeing the impairment as retribution. At the time of interview, participants’ ability in participating in daily tasks varied. Their remaining abilities principally dictated the types of activities they could carry out independently. Participants valued independence but viewed it as being more doing things without assistance. Whilst independence provided them with a sense of competence, dependence resulted in them being reliant on others, loosing privacy and being worried about the demands they were placing on others. Participants, who were dependent, primarily received assistance from their family members. Participants and their family thought that their family members assisted them because of a sense of responsibility, pity, and love. This indicated that participants and their significant others did not have a clear understanding of independent living which encourages people to avoid dependency on their families. Many traditional Thai practices and the importance of the extended family are at odds with the independent living movement which encourages disabled people to take responsibility in all aspects of their lives.
Participants reported a number of negative and positive impacts of impairment. In negative way, their abilities were decreased and resulted in them being confined and reacting emotionally to these frustrations. They perceived that they were devalued and unaccepted by people in the community. They also had limited work opportunities and less prestigious and financially rewarding jobs available to them. They also experienced family disruption, rejection and marital breakdown as a result of acquiring an impairment. In positive way, acquiring an impairment allowed some to consider who they were and reflect on their past. This opportunity for spiritual reflection helps them to refocus their life and strive towards 'better behaviour'.

Most participants realised the importance of independent living. From their perspectives, independent living had a number of benefits including 'achieving autonomy', 'obtaining sense of self-efficacy', 'gaining good consequences', and 'being able to contribute reciprocally to others'. Those who did not value independent living might be influenced by cultural values or have low self-efficacy.

When participants endeavoured to live independently, it was not a simple matter. When they were able to go into the community, the levels and types of community participation varied resulting from different levels of support being available and a range of barriers in the community. Different levels of participation reflected individual preferences and requirements. They were involved in a range of activities including 'participating with friends and relatives', 'visiting facilities in the community', and 'joining activities specifically for people with disabilities', to 'working for a people with disabilities group', and 'community work'. They experienced the reactions of non-disabled people towards them varied from 'not
reacting differently’, ‘staring’, ‘pitying them’, ‘looking down on them’, to ‘ostracising
them’ and ‘being abusive’. Participants’ control over decisions and their lives
depended on their contexts. Whilst impairments did not preclude them from making
decisions and having future plans, taking control over health services was considered
difficult for most participants. They had low expectations of health services and were
not able to take an active role in requesting what and how services were delivered.
However it was evident that the participants sought greater control over health
services. Most participants recognised that they should have the same rights as non-
disabled people, but they experienced difficulty when attempting to exert their rights.

Many personal and contextual factors influenced on them to attain independent living
including ‘sense of competence’, ‘knowledge and information’, ‘family’, ‘others
people and organisations’, ‘financial’, and ‘equipment, transportation and access’.
Appendix 4

Consent Form

TITLE: Independent Living: models and guidelines for practice for Thai occupational therapists

INVESTIGATOR(S): Mrs Jananya Dhippayom

Doctor of Philosophy Student
The Department of Occupational Therapy
School of Healthcare Studies
Cardiff University
UK

Dr. Gail Boniface
Project Supervisor
The Department of Occupational Therapy
School of Healthcare Studies
Cardiff University

Dr. Wynford Bellin
Project Supervisor
School of Social Sciences
Cardiff University

I, ............................................. (Please print) hereby consent to take part in the research project titled: Independent Living: models and guidelines for practice for Thai occupational therapists.
I acknowledge that I have read the information sheet provided, and that I have had the project, so far as it affects me, fully explained to my satisfaction by the investigators. I freely consent to my participation in the project.

The details of the procedure proposed have also been explained to me, including the anticipated length of time it will take, and an indication of any discomfort or possible risks that may be expected.

I understand that the purpose of this research is to develop guidelines for practice for Thai occupational therapists and identify appropriate models giving support independent living. My involvement may not be of any direct benefit to me.

I am informed that my identity and that my privacy will be maintained at all times. A pseudonym will be used in reports and publication.

I understand that I am free to withdraw from the project at any stage without penalty.

Signed: ......................................................... Date: ..............................

(Participant)

Signed: ......................................................... Date: ..............................

(Witness)

Note: This document was translated into Thai.
Appendix 5
Interview Questions

Interview questions before being modified.

1. What independent living means to you?
2. What do you think about independent living’s information provided?
3. What do you think about the example of cases provided?
4. Do you think independent living for disabled people in Thailand is feasible?
5. What can we do to support independent living?
6. How can we achieve our plans?
7. Do you think which models of practice are appropriate to use with independent living?

Interview questions after being modified.

1. What do you think about independent living’s information and the case examples provided?
2. What does independent living mean to you?
3. Do you think independent living for people with physical impairments in Thailand is feasible?
4. What can you do to support independent living? How can we achieve our plans?
5. Do you think which models of practice support independent living?

Note: These questions were translated into Thai.
Appendix 6

Case Examples

Case examples below might give you some ideas about life experience of disabled people in Thailand. Your personal experiences relating to disabled people might be similar or different with these case examples.

Case 1:
A 40 years old lady have had spinal cord injury (C6 level) 24 years ago. She lives with her parents and her brother's family in a house (above-ground basement). Except brushing and cleaning face, she normally receives assistance from her mother (78 years) in daily activities. Her sister-in-law sometime assists her when her mother is not available. However, she prefers to receive help from mother rather than sister-in-law because she does not want to be inconvenient sister-in-law. She is confined on a bed that is on upstairs of the house. All activities of daily living are undertaken on the bed. She has never gone outside and into the community since she acquired impairment. Her hobby is a crochet. She sometime earns money from crochet. A disabled organisation encourages her to register as a disabled person in order to get benefit provided by the Thai government. As she has severe impairment and never had a wheelchair, the organisation offers her a personal assistant, a wheelchair and transportation in order to go into the community. However, she does not like to go into the community. She feels fear of accident when she sees a lot of car on street. Besides, she does not like when people stare her. She loses confidence. Her family members try to encourage her to go into the community more often. She does not
want to go because she does not have money. She does not want to put financial load on family.

**Case 2:**

A 48 years old man has had a brachial plexus injury of right arm (dominance) 4 years ago. Before the accident, he was a head of family who earned money for family (a wife, and two children). He received surgical reconnection of nerves at a hospital. After the surgery, he received a follow up from a doctor every three months. He did not know what the doctor examined him in the follow up sessions. He did not brave to ask what the doctor was doing with his arm. The doctor told him that physiotherapy might help him to gain recovery. However, the doctor did not tell him where he could receive physiotherapy. Until now, he has never received physiotherapy. He cannot move his right arm. He is dependent in everything except eating. His wife helps him do things. He cannot work. He lets his wife to take responsibility to earn money for family. His family members also support him not to work because they think that a disabled person does not have ability to do anything. He feel embarrass that he is a disable. This results in him not desiring to go into the community. His family members also do not want him to go outside because they concern that he would get difficulty. He does not have any plan for his life because he feels hopeless. Financial limitation also prevents him from making any plan for his life.

**Case 3:**

A 36 years old man has had left knee amputee and paraparesis. He lives alone because his wife divorces him after acquiring impairments. He has been rejected from his parents because they concern that he would be a burden on them. At first, he wanted
to die because he could do nothing. However, he could accept his impairments finally. He tried to do things himself even though he failed several times. Currently, he is independent. He can go anywhere he wants by a modified tricycle. He normally asks people in the community to assist him if he cannot access any place because of lack of accessibility. He has his own business after being refused to work at a factory. He now earns about 20,000 baht a month from his business. However, people who see him usually pity him and give him money. He does not like when people pity him. He wants to change people’s attitude towards people with disabilities. He wants to help other people with disabilities to be independent like him.
Appendix 7

Checklist for Moderator

Moderator Evaluation

A. Moderator's preparation
   □ Understands the background and subject matter of the project
   □ Understands the research objectives
   □ Helped develop the topic guide
   □ Has the topic guide memorized
   □ Was ready before the group assembled

B. Moderator's manner
   □ Is relaxed and friendly
   □ Stimulates group interaction
   □ Generates enthusiasm and involvement
   □ Listens constructively
   □ Displays warmth and empathy
   □ Is non-judgemental
   □ Probes without leading
   □ Conveys "incomplete understanding" effectively
   □ Is sensitive to the level of group disclosure
   □ Blends in, but controls
   □ Improvises when necessary
   □ Is flexible when pursuing new ideas
   □ Discusses, but does not question
   □ Displays neutral body language and facial expressions

C. Moderator's handling of group influences
   □ Discourages simultaneous talking
   □ Retains group spontaneity
   □ Discourages irrelevant conversation
   □ Discourages intellectualizing by respondents
   □ Permits individual differences of opinion
   □ Brings shy or unresponsive group members into the discussion
   □ Controls dominant or disruptive group members

Structure of the Group Discussion

A. Introduction: Moderator's opining
   □ Put the respondents at ease
   □ Explained the general purpose of the group
   □ Encouraged conflicting opinions
   □ Established moderator neutrality
   □ Established openness: no right or wrong answers
   □ Gave group "rules"
   □ Began developing a rapport with the respondents
□ Provided a smooth transition to the next phase

B. Phase I: Warm-up
□ Established a good rapport with the respondents
□ Obtained necessary background information
□ Began stimulating group interaction
□ Gave all respondents an opportunity to speak
□ Successfully diminished speech anxiety
□ Established the group as a "safe place"
□ Enabled group members to know each other
□ Stayed within the time limits
□ Provided a smooth transition to the next phase

C. Phase II: Body of the group discussion
□ Moved from the general to the specific
□ Did not disclose key issues prematurely
□ Obtained a depth of response to key issues
□ Obtained member’s true feelings about topics
□ Linked information into a cohesive whole
□ Exhibited appropriate facilitation behaviour
□ Exhibited appropriate controlling behaviour
□ Provided a smooth transition to the next phase

D. Phase III: Closure
□ Identified key themes
□ Summarized key ideas
□ Revealed the strength of attitudes
□ Consolidated group feeling about issues
□ Identified individual differences of opinion
□ Gathered all respondent comments

Note: modified from Mary Debus (cited in Krueger 1998)
Appendix 8

The NVivo Coding Framework

<table>
<thead>
<tr>
<th>Themes and Subthemes</th>
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<tr>
<td><strong>Themes and Subthemes</strong></td>
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<tr>
<td>1. ความลำดับขั้นตอนแนวคิดเรื่องการคัดรูปตัวชี้วัดอิสระ</td>
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<td>- ความลำดับขั้นตอนแนวคิดเรื่องการคัดรูปตัวชี้วัดอิสระ</td>
</tr>
<tr>
<td>2. ระดับของการคัดรูปตัวชี้วัดอิสระ</td>
</tr>
<tr>
<td>- ลักษณะของการคัดรูปตัวชี้วัดอิสระ</td>
</tr>
<tr>
<td>- ปัจจัยที่ส่งผลต่อระดับของการคัดรูปตัวชี้วัดอิสระ</td>
</tr>
</tbody>
</table>

| **ความเป็นไปได้ของการคัดรูปตัวชี้วัดอิสระของผู้พิการในเมืองไทย** |
| 1. เบื้องต้น |
| 2. ต่อมาข้างหลัง ต่องผู้ด้อยโอกาส | |
|   - คุณพิการ |
|     - จิตใจของบุคคลภาพ |
|     - สภาพทางด้านร่างกาย |
|   - ครอบครัว |
|     - ทัศนคติของครอบครัวต่อความพิการ |
|     - การดูแลผู้พิการ |
|   - คนในชุมชน |
|     - ปฏิกริยาของคนในชุมชน |
|   - ผลกระทบ |
|     - ความอัตถิภัย |
Themes and Subthemes

- การสนับสนุนจากวัฒนธรรม
  - สิ่งแวดล้อมทางกายภาพ
  - วัฒนธรรม
- พระราชาบูรปัญญาและภูมิชีวิต
- ขาดความร่วมมือ
- แผนงานและแผนดำเนินการ

การสนับสนุนจากหลักการกรรมบัญชี

1. การกำหนดแนวทางชีวิตของตนเอง
   - การส่งเสริมให้เกิดความเข้าใจในความคิดก้าวหน้า
   - ส่งเสริมทักษะส่วนบุคคลการกำหนดแนวทางชีวิตของตนเอง
     - ส่งเสริมให้ผู้พิการท้าความต้องการของตนเอง
     - ส่งเสริมให้ผู้พิการกำหนดเป้าหมายในชีวิตและทำตามเป้าหมายที่ได้วางแผนไว้

2. การเรียนรู้ทางสิทธิของตนเอง
   - สร้างความเข้าใจเกี่ยวกับการเรียนรู้สิทธิ
   - ส่งเสริมให้ผู้พิการเรียนรู้สิทธิของตนเอง
     - ให้ข้อมูลเรื่องของการเรียนรู้สิทธิและสถานที่ที่ให้การดูแล
     - สร้างเสริมช่วยและให้ความร่วมมือกับผู้อื่น

3. กลุ่มพื้นที่พัฒนอง
   - ส่งเสริมแนวคิดเกี่ยวกับการพัฒนาตนเอง
   - ส่งเสริมให้ผู้พิการเข้าเป็นส่วนหนึ่งของกลุ่มพัฒนา
   - คงไว้ซึ่งการสนับสนุน
     - สนับสนุนกิจกรรมกลุ่ม
     - สร้างเสริมกลุ่มให้มีความเข้มแข็ง

4. การปรึกษาที่เพื่อน
   - เปิดโอกาสให้คนพิการให้พบกับคนพิการอื่นๆ ที่มีปัญหาคล้ายคลึงกัน
   - หาคนพิการที่บริการเห็นพ้องที่ให้คำปรึกษาและสนับสนุนด้านข้อมูล
   - ให้ข้อมูลเพื่อช่วยกับสถานที่ที่ให้การปรึกษาที่เพื่อน

5. สิทธิผู้บริโภค
   - ส่งเสริมให้ผู้บริโภคเกิดความเข้าใจเกี่ยวกับสิทธิผู้บริโภค
   - ส่งเสริมให้ผู้พิการเกิดความเข้าใจเกี่ยวกับสิทธิผู้บริโภค

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คุณสมบัติให้ผู้ช่วยมีบทบาทผู้บริโภค
- เลือกมุมมองของนักช่างบนบัตรที่มีต่อผู้พิการ
- ให้ข้อมูลเกี่ยวกับการอย่างเพียงพอและเปลี่ยนสถานะให้ผู้พิการเด็ก
- เปิดโอกาสให้ผู้พิการประเมินบริการที่ได้รับ

6. การมีสิทธิ์เท่าที่มีกัน
- ส่งเสริมให้เกิดความเข้าใจในเรื่องสิทธิผู้พิการ
- ให้การสนับสนุนผู้พิการให้รักษาสิทธิของตนเอง
  - สนับสนุนให้ผู้พิการรู้สึกถึงความเท่าเทียม
  - เตรียมสนับสนุนให้พร้อมสำหรับการเรียนรู้สิทธิของตนเอง
  - ให้ข้อมูลที่เจาะจงแก่คอมพิวเตอร์ที่เกี่ยวกับสิทธิของคนพิการ
  - ให้ความร่วมมือกับปลอดภัย/หน่วยงานอื่น

7. สิ่งแวดล้อมทางกายภาพที่เป็นอุปสรรค
- เด็กต้องมีโอกาส
  - ส่งเสริมความเข้าใจเกี่ยวกับความพิการให้กับบุคคลในสังคม
  - สร้างเสริมนักช่างทางบวกของตนเองในสังคมต่อคนพิการ
- สิ่งแวดล้อมทางกายภาพที่เป็นอุปสรรค
  - สร้างความร่วมมือของบุคคลที่เกี่ยวข้องกับสิ่งอันดับความสะดวกสำหรับคนพิการ
  - ให้การช่วยเหลือนักช่างสนับสนุนให้คนพิการเข้าสู่ชุมชน
  - ให้การช่วยเหลือนักช่างสนับสนุนกลุ่มผู้พิการในการเรียนรู้สิทธิที่เป็นการส่งเสริมความหลากหลาย

รูปแบบในการปฏิบัติงานที่สอดคล้องกับการดำเนินชีวิตอิสระ
- Client-centred Model
- Occupation-based model
- Medical model

ความต้องการของนักช่างบนบัตร
- ของานสู่ชุมชน
- ทักษะ: ทักษะการให้คำปรึกษาและทักษะทางสังคม
- ความรู้: การดำเนินชีวิตอิสระและความรู้สึกที่สัมพันธ์กับเรื่องการดำเนินชีวิตอิสระ
Appendix 9

Publications Directly Related to this PhD Thesis

Conference Proceedings and Abstracts:
