A STUDY FAMILY-BASED CARE FOR PEOPLE WITH SEVERELY DISABILITIES IN SAMAE DAM SUBDISTRICT BANG KHUN THIAN DISTRICT BANGKOK

TUNYALUK ROONGSANGJUN

A Dissertation Submitted in Partial
Fulfillment of the Requirements for the Degree of
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ABSTRACT

Title of Dissertation A STUDY FAMILY-BASED CARE FOR PEOPLE WITH SEVERELY DISABILITIES IN SAMAE DAM SUBDISTRICT BANG KHUN THIAN DISTRICT BANGKOK
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The objective of this study is to observe the situation, caring procedure, and model structure for caring for severely disabled people by family. This is qualitative research as data was collected by in-depth interviews with a sample of 6 disabled people, and 6 family members caring for disabled people who live in the Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, and disabled academic, disabled experts from government agencies and experts on disabled people from private agencies or civil society organizations at a total of 6 people. The collected data were analyzed through typological analysis followed by interpretation and analytic conduction.

The result of this study shows that severely disabled people who are under family care are not as severely unable to help themselves. The disabled people caring situation is cared for by family members who are related as a husband, son, nephew, brother, or sister at their own house. Caring procedure is a physical aspect as severely disabled people require close care from having little ability to help themselves or none at all, having illnesses both disability and congenital disease. Emotional and mentality caring which disabled people have an unacceptable feeling of disability and are unable to adapt at first to stress, worrying, and fear of being burdened and abandoned and welfare rights as disabled people and their families do not know their rights which the most accessible are healthcare rights and financial rights for disabled people. From the in-depth interview, then analyzing, synthesizing, interpreting, and crystallizing knowledge was found that the caring severely disabled people model requires holistic care in 5 follows: 1) Physical aspect, 2) Emotional aspect, 3) Spiritual aspect, 4) Social aspect and, 5) Welfare rights. 1) Knowledge is daily routine caring including food, medicine, physical therapy, and communication. 2) Required accessories for disabled people are adult diapers, a wheelchair, a cane for disabled people, suction, and first aid kits. 3) Care giver including personal assistant, public health volunteer, foster family, foster' home, etc. 4) Money including disability allowance, loans, and tax deductions, etc. 5) Group, namely, nature groups, clubs, associations, and foundations, etc. 6) Community including people in the community attitude, assistance in carrying and moving, employment, and monitoring and warning. The suggestion and recommendation in this study are to implement a prototype (model) studying caring disability people with severe disability through family prototypes in other provinces in Thailand or countries in the Asia region which have similar economic, and lifestyle models as Bangkok City.

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TUNYALUK ROONGSANGJUN
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CHAPTER 1

INTRODUCTION

1.1 Background and Importance of Issue

Country development at present should give priority to the human resource, an important factor for sustainable development. In the past, the world provides economic development as a main factor in developing the main trend (Amorn Raksasat, 2003), neglecting the social and human development aspect. The result of this development causes several issues, namely, pollution, crime, poverty, social inequality, etc., and becomes more severe. Moreover, another important issue is people are unable to access or overlook the development, one of these people is overlooked disabled groups and abandoned to live in poor conditions, and lack of life quality. Developed countries will not commit stability and prosperity to a one-dimensional economy as developing the country with advancement and stability has to develop the economy, society, and humans altogether as balanced development (Amorn Raksasat, 2003). Therefore, the development should not overlook the human resource development to develop the country equally and thoroughly as any country a good human resource with potential, physical, mental spirit, and intelligence is an advanced and developed country (Suan Sunandha Rajabhat University, 2023) and not overlooks the fragile people as disabled people require assistance and support from government, private and civil society sector.

Disable is a person with a handicap doing daily routine or participating in social activity due to physical, behavior, or mood issues or these issues combine (Department of Empowerment of Persons with Disabilities, 2023). Before 1991, the government, private, and civil society sectors in Thailand had an opinion towards disabled people as a group that requires being taken care of with compassion and humility without giving thought to protection and restoring them for continuously living in society. Later, an Act on Rehabilitation of Persons with Disabilities, B.E. 1991 was enacted, giving disabled people a definition as abnormal or having physical, intelligence, or mental condition, focused on the individual in an attempt to solve the issue individually by reducing disable or compensate through medical, prosthetics or Arrangement of various facilities. These equipment are categorized as “Medical Models”. There are several disabled types including visually impaired, hearing and communication impaired, physical or mobility disability, mental or behavioral disability, and intellectual or learning disability. Later, the Act on the Promotion and Development of the Quality of Life of Persons with Disabilities, B.E. 2007 was enacted, giving a disabled definition as a person who has a limit to performing daily routine or participating in society due to visual, hearing, movement, communication mental, mood, behavior, intelligence, learning or any other impaired condition (Supap, 2009) with various obstacle aspects which require special assistance to perform daily routine or participate in society as same as normal person. The difference aspect is for those who have which type of disability is not important but respecting equality as citizens, understanding different aspects, and eliminating obstacles in attitude and environment make disabled people live on as a normal person and good like quality in social model (Supap, 2009)

In the international, disable definition was given as The United Nations Universal Declaration of the Rights of Persons with Disabilities defines disability as a person who has any kind impair including physical or mental, whether it is congenital or not to the point of uncertainty that they will be able to live their lives like a normal person, whether in part or all, by themselves. (Center for Educational Media for the Disabled, 2013) while the Convention on the Rights of People with Disabilities (CRPD) defines disability as a person who has physical, mental, intelligence or sense impair in the long term when interacting with various obstacles. It will hinder their full and effective participation in society on an equal basis with other people (Department of Empowerment of Persons with Disabilities, 2022) and World Health Organization defines disability as impairment means loss or an abnormality of the physical structure or function, mental, or physiology, which may be temporary or permanent. Moreover, including anomaly loss or missing body parts, body mechanisms, and mental function system, for example, one side of the eye becomes blurred or unable to see. The limbs are paralyzed. Ear loss of hearing and develop psychotic symptoms, etc. (Disability Evidence Portal, 2011).

According to the Act on the Promotion and Development of the Quality of Life of Persons with Disabilities, B.E. 2007 and its amendments (No. 2) B.E. 2013, disability are categorized into 7 types: (1) Visually impaired disability (2) Hearing or communication disabilities (3) Physical disabilities (4) Mentally or behaviorally disability (5) Intellectually disability (6) Learning disabilities and (7) Autism disability (Department of Empowerment of Persons with Disabilities, 2021) as disabled people may, may not or unable to help themselves which categorized into 5 levels as shown in 1.1 table as follows:

Table 1.1 Level of Self-Help Ability of Disabilities

Disable People Skill Level	**Self-help Ability of Disabled People**
Level 1 ability	People who are unable to perform a daily routine at all or very little and have a high need for assistance from other people.
Level 2 ability	People who can perform a few daily routines but still need quite a lot of assistance from other people.
Level 3 ability	People who can help themselves a lot in their daily routine but may need assistance from someone to help, give advice or help beside or use disability aids equipment or improving personal equipment but are unable to leave the house even in a facilitated environment to disabled people.
Level 4 ability	People who can perform their daily routine but orthotics may be required or disability aids or improved personal equipment. Can leave the house to an environment that is conducive to disabled people.
Level 5 ability	People who can help themselves in their daily routine but may need to use assistive devices or improved

Disable People Skill Level	Self-help Ability of Disabled People
	personal equipment. Can leave the house like a normal person.

Note: Modified from Act on the Persons with Disabilities Empowerment and Quality of Life Promotion Act, B.E. (2007).

Disabled people who can help themselves in levels 1 and 2 have very little or none to help themselves and require personal assistant (PA) (Department of Empowerment of Persons with Disabilities, 2021), having a severe disability including disable from spinal cord injury causing movement hindering and limit condition in daily routine. For example, those unable to sit or stand, unable to take a bath, or have meals by themselves are in need of assistance and have the right to apply for personal assistance services for the disabled. This service is a government sector service provided for disabled people to be able to perform their daily routine with the objective of helping severely disabled people perform their daily routine independently, value, good quality and good life (Department of Empowerment of Persons with Disabilities, 2007). Disable people that able to help themselves as classified in levels 3-5 will have rights and protection for disabled people to live normal and happy life including (1) Medical (2) Education (3) Profession and (4) Social (Disability Quality of Life Promotion and Development Act, 2007)

The cause of disability can be categorized into 8 types as follows: (1) Congenital disability caused by internal components, including sex chromosome abnormalities. Abnormalities characterized by the addition of chromosomes and abnormal conditions of the hormonal system in the mother etc., or caused by external factors such as certain types of viral infections, taking certain medicines during the mother’s pregnancy, mother’s exposure to radiation when mother has less than 6 weeks pregnant, and malnutrition in the early stages of pregnancy, the age of the mother etc., (2) Disabilities caused by contagious disease, such as venereal disease, syphilis, and leprosy, etc., (3) Disabilities from malnutrition in children, including inadequate essential nutrients for the body and lack of protein, etc., (4) Disabilities from various types of mental illnesses, (5) Disability from alcoholism and various drugs addiction, (6) Disability from various dangers and injuries, (7) Disabilities from non-contagious diseases, including movement disorders, lung disease, deafness, and other diseases such as epilepsy and cancer, etc., (8) Disability from other causes, including the environment and incorrect medical treatment, etc. (The Thai Encyclopedia Foundation for Youth, 2023).

Caring for people with disabilities methods are categorized into 2 types as follows: (1) Institutionalization means supervision by government agencies. For Thailand, these include the Centers for the Protection and Development of Quality of Life for People with Disabilities and the Center for Potential Development of Persons with Autism and (2) Deinstitutionalization refers to the care of people with disabilities by non-government agencies, including Families-based Model and Community-based Model (Tunyaluk Roongsangjun, 2020).

From the perspective of principles and methods for caring for disabled people, other countries' research results show that Deinstitutionalization has a positive result on both the physical and mental of the disabled this model has been used for a long time and become more obvious in 1990 as U.S.A. has enacted the Americans with Disabilities Act (ADA) which is a law regarding the rights of Americans with disabilities, focusing on Deinstitutionalization to disable by supporting funds for caring disable people, creating social security, encouraging employment and others benefits to disable people and family or caregivers (U.S. Department of Justice, 2009).

In Europe, the study Community-based Services is a comprehensive service that helps the disabled to live in family community-based (European Expert Group on the Transition from Institutional to Community-based Care, 2012) which the scope includes employment, education, strengthening the potential of parents and caregivers to have knowledge and skills in caring for people with disabilities and have the ability to take care family relationships, participation in political and cultural, relaxation and activities of your own interest as well as travel for recreation which is access to specific services is the first condition for people with disabilities to live independently. The availability of services is therefore a right of people with disabilities according to United Nations guidelines. This service model makes customers or disabled and caregivers become more controllers than the Institutionalization model which provides several alternative choices, namely, services must be decided together with the family. In-home care services are available; receive counseling concerning your own needs. The main service providers include national, regional, local, municipal, and civil society organizations as well (European Expert Group on the Transition from Institutional to Community-based Care, 2012).

For the Asia region, Flagothier (2016) report stated that disabilities are the cause of child abandonment in foster homes (Alternative Child Care and Deinstitutionalisation in Asia) including in Sri Lanka, Nepal, Indonesia, India, Malaysia, Myanmar, and Thailand. Whether it is the illness or disability of the parents having a chronic disease and found that care was family-based in the Kinship care model which is an expanded family-based or friend or known person model as an official which is managed by the organization or according to a court order and unofficial when taking care a child without any associated organization related, fund supporting, living, or employment. However, this caring type depends on the country's culture as a family relationship; the negative consequences may happen as a caregiver may see a child as a burden, wage increase, and finally may end up as the child may expelled from school or foster (Flagothier, 2016).

Family is the main institution of society, a basis of important human and social development, and closely with disabled people. Therefore, caring for disabled people's family members is an individual close caring relationship and kinship, making disabled people become well physically and mentally in a happy mood (Charuayphon Suphap, 2009). It can be explained that family is an important institution that cares, helps, provides, and supports disabled people to improve their physical, mental, spiritual, and social aspects (Ratchanee Sansern et al., 2013). However, caregiving issues may happen as families may have inappropriate caring for their disabled people, not confident in providing care, are poor and do not have care equipment, violence against people with disabilities, incarcerate people with disabilities, abandon, and exploit disabilities including some families sent disable to the foster center as they think that caring for disabled people should be the responsibility of the state. However, it was found that this often causes many disabled to feel stressed, lonely, and depressed because of their feeling of missing home and family. This results in having less food or some people not eating at all and there are also problems in adaptation that result in physical and mental illness when being taken into the care of the disabled foster agency or government (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019).

Thailand is a country with many disabled people, according to the statistic report from the Department of Provincial, Administration Registration (Department of Empowerment of Persons with Disabilities, 2023) stated that in Thailand 2023, the number of disabled people with their own identification card as disable people are 2,167,745 people with 1,036,814 (47.79%) females and 1,130,931 (52.21%) males. Disability types are categorized as follows; (1) Movement or Physical 1,104,046 (50.81%), (2) Hearing or Communication 403,811 (18.64%), (3) Visual 184,522 (8.58%), 4) Mental or Behavioral 167,746 (7.76%), 5) Intellectual 146,725 (6.78%), (6) More than one type of disability 124,266 (5.76%), (7) Autism 19,822 (0.90%), (8) Learning 15,006 (0.69%) and (9) Disability type not specified 1,801 (0.08%) total of 2,167,745 people. Therefore, the expectation of the number of disability in Thailand may increase and become a major issue in Thailand as Thailand still has disabled people that in need of improving their potential chances, of accessing welfare, benefits, and other assistance from government sector efficiency, including education, rehabilitation services, employment, income and social services with less continuity. The issue of disabled people is still a problem in Thai society and is well-known but not as much importance and attention is given to it as it should be.

The research of the Department for Empowerment of Persons with Disabilities by Thapthim Siwilai (2022) found that in 2022, Bangkok City had 98,756 disabled people as the lifestyle in Bangkok is stressful, hectic, and high living costs and most people have to work. There is little time to care for people with disabilities. A community is an urban community that has different ways of living. Therefore, taking care of disabled people is difficult and affects the family care of the disabled. While information from the Department for Empowerment of Persons with Disabilities by Thapthim Siwilai (2022) stated that in Bangkok City, three areas with the most people with disabilities are as follows: the first is Samae Dam Subdistrict, Bang Khun Thian

District, with 2,846 people, the second is Din Daeng Subdistrict, Din Daeng District, with 2,279 people, and the third is Nong Khang Phlu Subdistrict, Nong Khaem District, with 1,673 people (Department of Registration Administration, 2022).

In Samae Dam Subdistrict, Bang Khun Thian District, Bangkok City has the most registered disabled people, the information from the Department for Empowerment of Persons with Disabilities stated that Samae Dam Subdistrict, Bang Khun Thian District has 1,470 males and 1,376 female totals of 2,486 disable a person. The disability type is categorized in Table 1.2 as follows:

Table 1.2 Number of Disabled People Categorized by Type of Disability in Samae Dam District Bang Khun Thian District Bangkok

Disability Types	**Sex**		**Total**
	Male	**Female**	
1. Visual	70	79	149
2. Hearing or Communication	206	258	464
3. Movement or Physical	689	749	1,438
4. Mental or Behavioral	113	84	197
5. Intellectual	115	68	183
6. Learning	41	15	56
7. Autism	53	10	63
8. More than one type of disability	182	112	294
9. Disability type not specified	1	1	2
Total	1,470	1,376	2,846

Source: Modified from Department of Empowerment of Persons with Disabilities (2023)

The above table shows that In Samae Dam Subdistrict, Bang Khun Thian District, Bangkok City has the highest number of movement or physical disability for 1,438 people followed by hearing or communication disability 464 people and more than one type of disability 294 people with disability type not specified as the lowest for 2 people.

Severely disabled people in Samae Dam Subdistrict are disabled people who are unable or have very little self-help, namely disabled from spinal cord injury, resulting in difficulty in movement and limitations in daily life. Disabled people with severe disabilities or have a disability so great that they are unable to perform the daily routine of living on their own, such as not being able to sit up or stand upright, unable to have meals, or bathe by themselves, etc. are required to have an assistant which usually is in the care of the family as caregiver family has a role on severe disable as follows: (1) Help, care, and encourage disabled people to help themselves in their daily lives as much as possible. (2) Help prevent or reduce the risk of complications from disabilities that may occur. (3) Give encouragement, thoughts, and good advice to the disabled to overcome various obstacles, and (4) provide basic information about the disabled in various aspects, including social, environmental, and health aspects, so that the disabled can have a better quality of life. (Khlong Dan Subdistrict Administrative Organization, 2020). Caring disabled has to be holistic, and integrated, covering all dimensions of care, including health promotion, complications prevention, treatment, and rehabilitation (Ratchanee Sansoen et al, 2013). A disabled person is therefore a person who may have abnormalities or defects without being handicapped and disabled without being disadvantaged (Kanitta Thewintharaphak, 2012).

Previously, there has been no study of family care for disabled with severe disabilities in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok, is an area in the capital city where people have a hustle and stressful lifestyle, isolation, and high living costs. A person who experiences severe disabilities is unable or has little ability to help themselves, or a caregiver, and caring is difficult and complicated. If there is a study explaining families caring for disabled people with severe disabilities take care of them. What are the guidelines for care? Is there a model for caring for disabled people with severe disabilities that is clear, concrete, and will be able to be applied in care to make it more appropriate? Caregivers are more confident in providing care to the disabled and their families will be strengthened, and self-reliant in caring for people with disabilities, with reduced dependency on the state, and reduced budgets. People with disabilities are cared for by good families, are physically and mentally happy, and can also use the results of the study to push for policies, laws, or measures to promote and support the care of people with severe disabilities continuously.

1.2 Research Questions

1.2.1 How do Families in Samae Dam Subdistrict Bang Khun Thian District Bangkok take care of severely disabled people?

1.2.2 What should be the guidelines for appropriate family care for severely disabled people?

1.3 Objectives of the Study

1.3.1 To study the situation of caring for disabled people with severe disabilities by families living in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok

1.3.2 To study guidelines for caring for disabled people with severe disabilities by families living in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok

1.3.3 To create a model for caring for disabled people with severe disabilities by families.

1.4 Scope of the Study

1.4.1 Content scope, this study focuses on studying the conditions, and guidelines, and creating models for disabled people with severe disabilities by families of disabled people, families taking care of disabled people in Samae Dam Subdistrict, Bang Khun Thian District Bangkok.

1.4.2 Area scope and target group, this study used the unit of analysis: families and people with severe disabilities living in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok the researcher planned to select the area for use in the study by selecting the area with the highest number of registered disabled people in Bangkok and the unit of analysis is an academic or a disability expert.

The sample group in the study was divided into 3 groups: (1) 6 disabled people, namely disabled people with severe disabilities have been under the care of the family continuously for 3 years or more, aged 18 years and over, (2) A family caring for disabled people, 6 people, a family that has continuously cared for disabled people with severe disabilities for 3 years or more, aged 18 years and over, and 3) 6 academics or experts on people with disabilities, namely (1) academics with expertise in people with disabilities, (2) experts on people with disabilities from government agencies, and (3) experts on people with disabilities from private organizations or civil society.

1.4.3 Time scope, the duration from the beginning of the research until its completion took a total of 10 months (December 2023 to September 2024), divided into 4 phases: (1) The first phase, December 2023 to February 2024, reviewed the literature, research design and proceed with requesting in human research ethics. (2) The second phase, March 2024 to May 2024, collects data and analyzes preliminary data. (3) The third phase, June 2024 to July 2024, analyzes data and summarizes and discusses the results of the study, and 4) The fourth phase, August to September 2024, modifies the thesis according to the recommendations of the committee. Completeness checks and prepares a thesis book.

1.5 Significant of the Study

1.5.1 To acknowledge and understand the situation of caring for disabled people with severe disabilities by families living in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok

1.5.2 To make awareness and understand the guidelines for caring for disabled people with severe disabilities whose families live in the Samae Dam Subdistrict. Bang Khun Thian District Bangkok

1.5.3 To create a model for caring for disabled people with severe disabilities by families.

1.6 Definition of Terms

1.6.1 Disabled people with severe disabilities mean people with severe disabilities or have a disability so great that they are unable to perform the daily routine of living on their own, including being unable to sit up or stand; unable to have a meal or take a bath on their own, etc. need someone to provide assistance, have the right to apply for the services of a Personal Assistant (PA) who is registered as a disabled person. Living in the care of a family for 3 years or more in Samae Dam Subdistrict, Bang Khun Thian District Bangkok

1.6.2 Caring for disabled people with severe disabilities by families means taking care of their physical, emotional, mental, and various welfare rights by families with whom they are related by blood. or legal, including spouses both registered and unregistered, parents, adoptive parents, adopted children, and relatives, etc., living and caring for disabled people with severe disabilities for 3 years or more in Samae Dam Subdistrict, Bang Khun Thian District Bangkok

1.6.3 Model caring for disabled people with severe disabilities by families refers to guidelines for caring for disabled people with severe disabilities by families in the physical aspect. Emotional aspect spiritual aspect, social aspect, and welfare rights aspect

CHAPTER 2

CONCEPTS, THEORIES, DOCUMENTS, AND RELATED RESEARCH

In studying the care of severely disabled individuals by families in Sam Dum Subdistrict, Bang Khun Thian District, Bangkok, the researcher has utilized various concepts, theories, and related research as guidelines for the study as follows.

2.1 Concepts related to people with disabilities

2.2 Concepts related to the care of people with disabilities

2.3 Rules, regulations, and policies related to people with disabilities at the international level

2.4 Rules, regulations, and policies related to people with disabilities at the national level

2.5 Concepts related to the family

2.6 Concepts of development management

2.7 Related research

2.1 Concepts Related to People with Disabilities

2.1.1 Definition of Disability

Internationally, the definition of disability is provided by various sources. The United Nations Universal Declaration on the Rights of Disabled Persons offers an interesting definition of disability as follows: “Disability” refers to any individual who has a physical or mental impairment, whether congenital or not, that results in uncertainty about whether they can live independently like a normal person, either partially or wholly (Center for Educational Media for the Disabled, 2013). Additionally, the Convention on the Rights of Persons with Disabilities (CRPD) defines persons with disabilities as those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (Department of Empowerment of Persons with Disabilities, 2022). The World Health Organization defines “disability” as an impairment, which means the loss or abnormality of body structure or physiological or mental function, whether temporary or permanent. This includes organ anomalies, the loss or absence of organs, as well as body mechanisms and mental function systems. For example, one may experience blurred or lost vision in one eye, paralysis of limbs, hearing loss, or mental and neurological disorders.

In terms of language usage, the words “disability” and “handicap” in English can be distinguished as follows (Kanitta Thewintharaphak, 2012) Disability generally refers to the loss of ability to perform certain tasks due to physical impairments, such as the loss of limbs, blindness, or behavioral and intellectual abnormalities. These disabilities can be measured, such as a person with atrophied or amputated legs being unable to walk normally, or a blind person being unable to read regular print. This means that people with disabilities are unable to do some things that ordinary people can do.

In Thailand, the definition of disability has existed since before 1991. The traditional Thai societal perspective on people with disabilities viewed them as needing charity and compassion to survive, according to humanitarian principles. This perspective did not emphasize prevention or rehabilitation to enable people with disabilities to live in society like others. It was not until the enactment of the Rehabilitation of Disabled Persons Act, B.E. 2534 (1991), that rehabilitation, including medical, educational, vocational training, and employment, began to receive significant attention. This law defines “disabled persons” as individuals with physical, intellectual, or mental impairments. In other words, the focus was on the disabilities of individuals and addressing each person’s problems by reducing or compensating for the disability through medical means, assistive devices, or various facilities. Most of these approaches emphasize the medical model.

The Rehabilitation of Disabled Persons Act, B.E. 2534 (1991), states that “disability” refers to individuals with physical, intellectual, or mental abnormalities or impairments according to the types and criteria set forth in the ministerial regulations.

These disabilities are categorized into various types, including visual impairments, hearing and communication impairments, physical or mobility impairments, mental or behavioral impairments, and intellectual or learning disabilities. Later, in 2007, the Promotion and Development of the Quality of Life of Disabled Persons Act, B.E. 2550 (2007), was enacted, repealing the Rehabilitation of Disabled Persons Act, B.E. 2534. This new law provides a broader perspective on the dimension of “disabled persons.” According to this act, “disabled persons” are defined as individuals who have limitations in performing daily activities or participating in social activities due to impairments in vision, hearing, mobility, communication, mental, emotional, behavioral, intellectual, learning, or other impairments. These individuals also face various obstacles and have special needs that require assistance to perform daily activities or participate in social activities like others. The different dimension introduced by this act emphasizes that the specific nature of the impairment or disability is not the main focus. Instead, it stresses respecting human dignity, civil rights equality, understanding the dimension of diversity, and eliminating attitudinal and environmental barriers. This approach, known as the social model, enables disabled persons to live like others and have a good quality of life (Department of Empowerment of Persons with Disabilities, 2022, p. 9). Therefore, the meaning of “disability” can be summarized as shown in Figure 2.1.

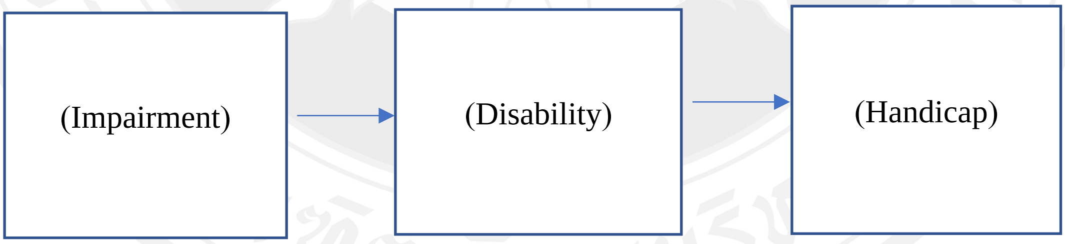


Figure 2.1 Definition of Disability
Source: Hammerman and Maikowski (1981, pp. 149-166).

Impairment or condition that does not result in disadvantage or disability allows individuals to maintain their daily lives without limitations in various activities such as work, education, or other daily activities, similar to any other person. Such impairments may stem from physical or mental factors affecting bodily functions or the brain, such as partial sight or hearing loss. However, with the aid of technology or assistive devices, individuals can lead their lives as normally as possible.

2.1.2 Types and Levels of Disabilities

In every country around the world, regardless of their level of development—whether classified as developed, developing, or underdeveloped—all have populations with disabilities. Thailand is one such country with a significant population of 2,167,745 individuals with disabilities, accounting for approximately 3% of the total population (Department of Empowerment of Persons with Disabilities, 2023). According to the Rehabilitation of Persons with Disabilities Act B.E. 2550 (2007) and its amendments (second version in B.E. 2556), disability is defined as a condition where individuals have limitations in performing daily activities or participating in social life due to various impairments and barriers. Disabilities can be categorized into 7 types as follows.

2.1.2.1 Visual Impairment
2.1.2.2 Hearing Impairment or Communication Impairment
2.1.2.3 Physical or Mobility Impairment
2.1.2.4 Psychosocial or Behavioral Impairment
2.1.2.5 Intellectual Impairment
2.1.2.6 Learning Impairment
2.1.2.7 Autistic Impairment

Additionally, individuals with disabilities are assessed based on 5 levels of ability.

Level 1: Individuals who cannot perform daily activities at all or very little and require significant assistance from others.

Level 2: Individuals who can perform some daily activities but still require considerable assistance from others.

Level 3: Individuals who can perform many daily activities but may require some assistance, advice, or monitoring from others or may use assistive devices. They may not be able to go out independently for education, work, or social activities even though their environment is supportive.

Level 4: Individuals who can perform daily activities independently but may require assistive devices or adjustments to personal belongings. They can go out independently for education, work, or social activities in a supportive environment.

Level 5: Individuals who can perform daily activities independently. They may require assistive devices or adjustments to personal belongings but can go out independently for education, work, or social activities similar to individuals without disabilities.

Thus, according to the Rehabilitation of Persons with Disabilities Act B.E. 2550 (2007) and its amendments (second version in B.E. 2556), individuals with disabilities can be categorized into two main groups based on their ability to assist themselves: 1) those who cannot assist themselves and require assistance (Levels 1-2), and 2) those who can assist themselves to varying degrees (Levels 3-5).

2.1.3 Criteria for Defining Characteristics of Each Type of Disability

The Department of Empowerment of Persons with Disabilities (2023) has established the characteristics of each type of disability as follows.

2.1.3.1 Visual Impairment

1) Blindness is the condition where a person has limitations in performing daily activities or participating in social activities due to visual impairment. This includes having worse vision when tested with eyeglasses than the standard of 3/60 or 20/400 up to not being able to see even light or having a visual field narrower than 10 degrees.

2) Low vision is the condition where a person has limitations in performing daily activities or participating in social activities due to visual impairment. This includes having vision worse than 3/60 or 20/400 when using standard eyeglasses, up to worse than 6/18 or 20/70, or having a visual field narrower than 30 degrees.

2.1.3.2 Hearing Impairment or Communication Disability

1) Deafness: This refers to limitations in performing daily activities or participating in social activities due to impaired hearing. This impairment results in an inability to receive information through hearing. When hearing is tested

using frequencies of 500 Hz, 1000 Hz, and 2000 Hz in the better-hearing ear, hearing loss is significant at 90 decibels or more.

2) Hard of Hearing: This refers to limitations in performing daily activities or participating in social activities due to hearing impairment. When hearing is tested using frequencies of 500 Hz, 1000 Hz, and 2000 Hz in the better-hearing ear, hearing loss ranges from 40 to 90 decibels.

3) Communication Disability: This refers to limitations in performing daily activities or participating in social activities due to disabilities in communication, such as inability to speak, or speaking and listening in ways that others cannot understand.

2.1.3.3 Physical Disability or Impairment

1) Physical Disability: This refers to limitations in performing daily activities or participating in social activities due to impairment or loss of function of body parts such as hands, feet, arms, or legs. This condition can result from causes such as cerebral palsy, limb weakness, limb amputation, or chronic illness affecting the function of hands, feet, arms, or legs.

2) Physical Impairment: This refers to limitations in performing daily activities or participating in social activities due to abnormalities or abnormalities in the head, face, torso, and external appearance of the body that are clearly visible.

2.1.3.4 Psychological, Behavioral, or Autistic Disability

1) Psychological or Behavioral Disability: This refers to limitations in performing daily activities or participating in social activities due to mental or brain impairments in the perception of emotions or thoughts.

2) Autism Spectrum Disorder (ASD) refers to limitations that individuals experience in performing daily activities or participating in social activities, resulting from developmental impairments in social interaction, communication, understanding meanings, behaviors, and emotions, caused by abnormalities in the brain. These impairments typically manifest before the age of 2 and may include other diagnoses within the autism spectrum, such as Asperger syndrome. Intellectual Disability (ID) refers to individuals who have limitations in performing daily activities or participating in social activities due to slower than

normal development or lower intellectual functioning compared to the general population, with symptoms typically appearing before the age of 18.

2.1.3.5 Learning Disability

It refers to individuals having limitations in performing daily life activities or participating in social activities, particularly in learning. These limitations stem from brain impairments, resulting in deficiencies in basic learning skills such as reading, writing, arithmetic, or other fundamental cognitive processes, which fall below age and intelligence norms (Department of Empowerment of Persons with Disabilities, 2023, p. 1).

2.1.4 Causes of Disabilities

The causes of disabilities are categorized into 8 types as follows:

2.1.4.1 Congenital Disabilities Caused by Internal Factors include abnormalities in sex chromosomes, chromosomal abnormalities involving additions, abnormalities in the mother's hormone system during pregnancy, such as infections by certain viruses, consumption of certain medications, exposure to radiation before 6 weeks of pregnancy, compression during pregnancy, and maternal malnutrition during early pregnancy due to advanced maternal age, and others.

2.1.4.2 Disabilities Caused by Infectious Diseases include leprosy, syphilis, and tuberculosis.

2.1.4.3 Disabilities from Malnutrition in Children, such as vitamin deficiencies, protein deficiency, etc.

2.1.4.4 Disabilities from Various Types of Mental Disorders.

2.1.4.5 Chronic Alcoholism and Substance Abuse Disabilities.

2.1.4.6 Various Hazards and Injuries.

2.1.4.7 Disabilities from Non-communicable Diseases such as musculoskeletal disorders, lung diseases, deafness, and other diseases like epilepsy, cancer, etc.

2.1.4.8 Disabilities from Other Causes including environmental factors and improper medical treatment (The Thai Encyclopedia Foundation for Youth, 2023).

2.1.5 Characteristics of Disability Identity

Kamlapan Panpeung (2008, pp. 82-109) categorizes disability identity into 5 characteristics:

First Characteristic: Individuals acknowledge the presence of disability in society but do not identify disability as part of their own identity. They may say to themselves, “I am not disabled.” This perception often occurs when individuals experience physical impairments before fully recognizing themselves as disabled, or during early stages when they have physical deficiencies but have not yet acknowledged them as disabilities. Individuals in this category may be undergoing treatment or physical rehabilitation, hoping that the disability will diminish on its own. They often avoid interaction or learning from people with disabilities because they do not want to be associated with the disabled group, fearing being labeled as disabled. There is often fear towards disability, stemming from the physical differences perceived as unattractive or intimidating, and discomfort or sympathy when encountering people with disabilities. Individuals in this group seek treatment and rehabilitation in various ways, hoping for a reduction or disappearance of the disability. They avoid using the term “disabled” for themselves or being referred to as such by others, viewing the term as symbolizing helplessness, undesirability, and inadequacy. They prefer terms like “ill” or others, feeling that being ill implies a condition that can be cured and is more desirable than being disabled, as it implies the possibility of recovering from physical impairments.

Second Characteristic: Individuals accept that “I am a person with a disability” and lead a satisfactory life within their homes or safe personal spaces. This acceptance usually comes after a period has passed, and they realize that their physical condition of disability has not disappeared. Some individuals use assistive devices more often after continuous physical training, such as being able to push their wheelchair further or raise their arms higher. However, overall physical conditions do not change significantly after undergoing various treatment and rehabilitation methods. For individuals with mobility impairments who cannot move independently, they often live their daily lives to survive, feeling repetitive boredom, despair, lacking enthusiasm, “living day by day,” and canceling goals in life. Some who have opportunities to meet other people with disabilities and learn about their lives or explore ways to help themselves or engage in activities with disabilities that enable them to function better in life. For example, they know how to adjust their living environment to accommodate the use of wheelchairs. They feel that they can manage their lives well within the home or community boundaries where people are familiar. However, individuals still feel ashamed, not wanting to reveal themselves to the public unfamiliar. Some feel less embarrassed because they have more opportunities to interact with people in the community, as they go out for business or work outside their homes and realize that some groups in society are not interested in their disabilities alone, but rather their ability to work or their achievements. However, individuals are still thinking about their disabilities under the negative language of society and have no confidence in some things. Not showing their full self, using the lines of social divides people into normal and disabled people as criteria for their roles, confident some limitations integrate into society.

Third Characteristic: Individuals embrace their disability identity positively and expand it into publicly declaring themselves. This means that individuals give a positive meaning to their disability, generally being those who have experienced participating in self-help activities for people with disabilities. They have interacted with groups of people with disabilities who lead happy lives or so-called disability role models. They themselves have started to experiment with various activities in life that they never thought possible before for a period, achieving satisfactory results for themselves. Individuals discover new ways to build relationships with people around them by asking for or receiving help, making them aware that they could produce beneficial activities for themselves and society. The disability is not a major obstacle in life. Individuals feel that they are part of the disabled community, accepting the meaning of disability anew from the philosophy of living independently or social disability concepts in themselves, such as disability rights. The individual feels confident that they can live with disabilities, expressing themselves fully, without feeling embarrassed or needing to depend on others. They can confidently share their life stories with disabilities in public, participate in social activities, interact with the public on a wide scale, regardless of how others perceive their disabilities.

Fourth Characteristic: Individuals join as members of the disabled community and participate in the social movement of people with disabilities. Individuals attribute meaning to themselves as members of the disabled community and actively engage in self-help groups for people with disabilities. They see participation in groups of people with disabilities as a space to express themselves in activities that benefit society or assist fellow disabled friends, following the concept of mutual aid. They understand the diverse needs of various groups of people with disabilities and see group unity as a way to unite forces to advocate for social rights. There is a consciousness of civic duty regarding the responsibility and rights to participate in society.

Fifth Characteristic: Individuals accept disability as a natural part of human diversity, linking feelings about issues with oppressed groups in various social groups. They view disability issues as part of overall social development, feeling satisfied with living with disabilities. They accept their limitations and are open to receiving assistance in various areas, as well as mutual dependence as a natural part of human nature. They also have experience or contact with the lifestyle of oppressed groups in other social groups and see similarities in the problems faced by disabled people. Moreover, they have an attitude to protect the human rights of disabled groups and, at the same time, can criticize the inclusion of disabled people directly on the pros and cons.

2.2 Concepts Related to the Care of People with Disabilities

Concepts related to the care of people with disabilities encompass perspectives both internationally and within Thailand. These include institutional care and community-based care (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019, pp. 25-62).

2.2.1 Concepts of Caring for People with Disabilities in Other Countries Caring for People with Disabilities Can Take Two Forms

Institutional care and community-based care, which are prevalent in many countries today. Numerous studies indicate that community-based care is a beneficial and appropriate approach for caring for people with disabilities, contributing positively to their physical and mental well-being. Family-based care for people with disabilities outside of institutions has been a long-standing and increasingly clear model since the 1990s, notably with the United States' enactment of the Americans with Disabilities Act (ADA), which emphasizes the rights of American citizens with disabilities. This legislation supports and funds care for people with disabilities, promoting social stability, employment, and other benefits for individuals with disabilities and their families or caregivers (U.S. Department of Justice, 2009).

In Europe, studies on community-based services within the European Union describe these services for people with disabilities as comprehensive, enabling them to live in community settings within family environments (Group on the Transition from Institutional to Community-based Care, 2012). These services cover aspects such as employment, education, enhancing parental and caregiver skills in caring for people with disabilities, fostering relational abilities within families, civic and cultural participation, recreational activities, and travel for relaxation and personal interests. Access to specialized services is a primary condition for people with disabilities to live independently, and service readiness is considered a right of people with disabilities following United Nations guidelines. Across EU member states, community-based services include in-home services, small-scale residential care, and day care centers, while family foster care, less commonly found, exists in 26 countries. Less prevalent services include non-professional peer support and counseling, informal support from others, befriending services, and circles of support. In such care models, service users or people with disabilities and their caregivers have greater control compared to institutional care models. Decisions regarding various service options require family involvement. In-home care services respect individual needs and preferences, with main providers ranging from national organizations to regional and local levels, including social services and health services. Social enterprises also play a significant role, particularly in providing befriending services, circles of support, crisis intervention activities, day care services, in-home care, personal assistance funded based on necessity, and family support/respite care (Group on the Transition from Institutional to Community-based Care, 2012).

From Catherine Flagothier's research on "Alternative Child Care and Deinstitutionalisation in Asia" (2016) According to the report, disability is cited as a leading cause for placing children in institutions across Sri Lanka, Nepal, Indonesia, India, Malaysia, Myanmar, and Thailand, whether due to parental illness or disability, or chronic illness. Additionally, family-based care, known as "Kinship care," is highlighted as a prominent alternative. This involves care provided by extended family or friends who are familiar with the child, both formally through organizational or court-appointed management, and informally without delegated authority from relevant agencies. Support may include financial aid, housing, and employment. However, the effectiveness of such care often depends on cultural norms regarding familial ties. Negative impacts may arise if caregivers perceive the child as a burden, leading to increased costs. Ultimately, children may face expulsion from school or abandonment in institutions.

2.2.2 Instituional Care

Institutional care for persons with disabilities involves clear formats, processes, and procedures managed by state or national agencies. In Thailand, this typically falls under the operations of the "Protection and Development Center for Persons with Disabilities," overseen by the Department of Empowerment of Persons with Disabilities, Ministry of Social Development and Human Security. Each institution provides care categorized by gender, age, type, and severity of disabilities, operating round the clock with staff such as nurses, social workers, psychologists, physiotherapists, and caregivers. Primary caregivers are responsible, while relatives, local communities, or other organizations do not directly participate in the care of persons with disabilities in these institutions (Rapeepan Kamhom & Thanyalak Rungsangchan, 2019, pp. 87-88). In summary, institutional care concepts can be categorized into three types:

1) Full-time Care by Government Agencies: Disabled individuals receive full-time care services from state agencies, available 24 hours a day.

2) Partial Care by Government Agencies: Disabled individuals receive care services during specific times, such as round-trip services or limited services like

vocational training, rehabilitation, job placement counseling, welfare rights, and healthcare.

3) Basic Care by Government Agencies: Basic care services are provided by state agencies to prepare individuals for referral to other institutions, such as other disability protection centers, returning to original families, benevolent families, or placements in government and private sector training and work units. Thailand has 13 institutions for disability care, as indicated in Table 2.1.

Table 2.1 Care for Disabled Individuals in Institutions in Thailand

Shelters and Development Centers for Persons with Disabilities	**Services Categorized by Characteristics**		
	Types of Disabilities	**Gender**	**Age Range**
1. Protection and development center for persons with disabilities: Ban Feung Fah	All types	All genders	newborn to 7 years old
2. Protection and development center for persons with disabilities: Ban Nonthapum	All types of disabilities	All genders	7-18 years old
3. Protection and Development Center for Persons with Disabilities - Ratchawadi House (Male)	Intellectual disability	Male	7-18 years old
4. Protection and Development Center for Persons with Disabilities - Ratchawadi House (Female)	Intellectual disability	Female	7-18 years old
5. Protection and Development Center for Persons with Disabilities - Ratchaburi House	Intellectual disability	Female	7-18 years old
6. Protection and Development Center for Persons with Disabilities - Karunyawat House, Chonburi Province	All types of disabilities	Female	18 and above
7. Protection and Development Center for Persons with Disabilities	All types of disabilities	Male	18 and above

Shelters and Development Centers for Persons with Disabilities	Services Categorized by Characteristics		
	Types of Disabilities	Gender	Age Range
- Bang Pakong, Chachoengsao Province			
8. Protection and Development Center for Persons with Disabilities - Phra Pradaeng House, Samut Prakan Province	All types of disabilities	All genders	18 and above
9. Protection and Development Center for Persons with Disabilities - Ubon Hakpaeng House, Ubon Ratchathani Province	All types of disabilities	All genders	18 and above
10. Protection and Development Center for Persons with Disabilities - Kungwitheechai House (Male), Pathum Thani Province	Psychiatric disability	Male	18 and above
11. Protection and Development Center for Persons with Disabilities - Kungwitheechai House (Female), Pathum Thani Province	Psychiatric disability	Female	18 and above
12. Autism Development Center, Nonthaburi Province	Autistic disability	All genders	12-25 years old
13. Autism Development Center, Khon Kaen Province	Autistic disability	All genders	12-25 years old

Source: Rapeepan Kumhom and Tunyaluk Roongsangjun. (2019, pp. 87-88).

The institutional care for disabled individuals often involves clear planning, programs, processes, and well-defined steps. It tends to be formalized with limited flexibility and minimal involvement of service users in decision-making and planning for their own care. The service delivery models for different types of disabilities sometimes follow a similar or identical "one size fits all" approach. This institutionalized approach to caring for disabled individuals has led to interesting service delivery models, such as:

The institutional care process for disabled individuals proposed by Rapeepan Kumhom and Tunyaluk Roongsangjun (2019, pp. 25-62) includes three processes:

1) The initial process of receiving disabled individuals involves the establishment of a protection and development center as the service provider. The process includes:

The initial reception process for disabled individuals varies among protection and development centers, each of which sets criteria and qualifications based on the specific services they provide. These criteria may include age, gender, nationality, ability to care for oneself, type of disability, and necessary documentation from the disabled individuals.

When assisting people with disabilities upon initial encounter, there are two types of approaches:

Regular Assistance: This involves visits by provincial disability service centers or offices for the protection and development of persons with disabilities. They provide basic assistance such as verifying rights and explaining disability rights when under protection and development. Additionally, they coordinate with local agencies such as community leaders, village heads, local administrative organizations (TAO), and volunteers to provide necessary assistance, including information and factual comparisons of various options while awaiting admission to protection and development centers.

Emergency Assistance: This involves emergency response for disabled individuals who are victims of abuse or sexual assault. Response units can take immediate action within a maximum period of 15 days to handle documentation, arrange hospital referrals or medical examinations, and provide legal assistance.

The establishment of a reception center or initial reception room aims to verify documentation, monitor behavior and symptoms of illness, and allow disabled individuals time to adjust before entering protection and development centers. This period typically lasts between 14-30 days and is managed by a multidisciplinary team including social workers, nurses, physiotherapists, and psychologists. Once the initial reception process is complete and if the disabled individual has no outstanding issues, they can proceed to receive services at the protection and development center. However, if issues arise during this period, such as health problems, they will be referred to hospitals for treatment according to their healthcare rights. Legal issues will be referred to relevant legal authorities such as the police or court, as necessary.

2) Development Process:

The service provision involves assessment and screening of disabilities, which includes evaluating documentation, personal history, illnesses, and capabilities. This process aims to develop and provide tailored development plans based on the individual's needs, abilities, and requirements. These services include physical rehabilitation, mental health recovery, and individualized plans such as the Individual Rehabilitation Plan (IRP) or Individual Education Program (IEP). It also encompasses physical and mental health care, vocational training, occupational therapy, mainstream education, activities of daily living (ADL), social skills training, and development of Individual Quality of Life Plan (IQLP). Disabled individuals are grouped into four categories based on their abilities:

Group A consists of disabled children or individuals who can independently perform daily activities, are ready for education, preparedness, or vocational skills training, capable of pursuing a profession, and can develop social skills.

Group B includes disabled children or individuals who can partially perform daily activities with minimal assistance, have access to vocational skills training, require occasional guidance or close supervision for social integration.

Group C comprises disabled children or individuals with severe disabilities who cannot independently perform daily activities and require constant assistance for tasks like eating, bathing, or toileting. They can participate in basic vocational skills training, life skills training within protection and development centers, and social skills training for interaction with others.

The bedridden group consists of disabled children or individuals with severe disabilities who cannot independently perform daily activities and require constant assistance from others. They are unable to move on their own and may use assistive devices such as feeding tubes or suction machines. They always need close supervision and care. (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019, pp. 36-37).

3) Process of Integrating Disabled Individuals into Society

The process of reintegrating disabled individuals into society can be done in 4 ways: (1) returning them to their original family, a foster family, or a philanthropic family, (2) referring them to protective and development centers for the disabled, (3) employing disabled individuals to promote self-reliance, and 4) sending them to vocational training centers for the disabled.

Returning individuals with disabilities to their original families will be managed by social workers, who will visit the homes and assess the families' readiness to take back the individual with disabilities before sending them back. In most cases, individuals with disabilities will be temporarily returned to their families for a period of about 1 week to 1 month.

For referrals to other organizations for services, they will be based on the individual's needs and problems. Before making a referral, there will be an assessment by professionals. For example, if the referral is for further education or vocational training, it will be evaluated by relevant professionals before the referral is made. Once individuals with disabilities are referred to another organization, they will be monitored and evaluated based on their specific needs and abilities. Monitoring and evaluation will be done by professionals in the relevant fields, such as nurses for health-related issues, physical therapists for rehabilitation, etc. After the individuals with disabilities receive services from other organizations, they will be followed up by social workers and other professionals as needed. The frequency of follow-ups will decrease over time to every 3 to 6 months, with occasional phone check-ins to inquire about their well-being and any issues they may be facing.

The care provided to individuals with disabilities at Autistic Person Development Centers will differ from other protective and developmental organizations. They will provide a going-back-home model, where individuals with disabilities stay with their families and communities. Families will send individuals with disabilities to the centers for social and vocational skills training and other necessary skills for daily living. Families or caregivers will also receive training on caring for individuals with disabilities, and the centers will be the only institution to provide this type of care, with no overnight stays or permanent residence. An important condition is that families and caregivers must participate in the care provided by the centers. In Thailand, there are two Autistic Person Development Centers, one in Nonthaburi Province and one in Khon Kaen Province. (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019).

2.2.3 DeInstitutional Care

Care for disabled individuals outside institutions involves the support, promotion, and development, as well as the protection of the welfare of disabled individuals outside of institutional settings. This approach enables families, communities, local entities, and partners such as non-governmental organizations (NGOs), private organizations, social welfare organizations, disability organizations, and religious organizations to participate in the care of disabled individuals. It is a form of care that is not administered by government agencies (Tunyaluk Roongsangjun, 2020, pp. 106-107). The concept of care outside institutions emphasizes and respects the rights of disabled individuals, allowing them to live independently, be self-reliant, and make their own decisions. It also views social welfare as essential for enhancing the quality of life, well-being, and human dignity of disabled individuals, ensuring they are on equal footing with other population groups in society. This approach to care is flexible and informal, allowing plans or care methods to be adjusted to suit the individual needs, types, and severity of disabilities, as well as the specific needs or issues of each disabled person and their family. There are two models of care under the DeInstitutional Care approach:

1) Families-based Model

This model emphasizes caring, supporting, and empowering families to care for people with disabilities. Families play a key role in providing care for people with disabilities, from birth or in cases of disability later in life. The type and quality of care provided may vary depending on economic resources, social context, networks, and problems. Each family may provide care in a different way depending on their internal relationships, economy, and social network.

2) Community-based Model

It involves caring for, promoting, and supporting disabled individuals to live in the community, with the community participating and playing a role in their care along with the family or caregiver. The services provided give disabled individuals and their families the opportunity to choose from the following options:

(1) In-home Services: These include assistance with household tasks such as shopping, cleaning, cooking, daily living activities, bathing, dressing, laundry, and medication management.

(2) Day Care Centres: These are services where disabled individuals are left under the care of the community, utilizing appropriate locations based on the social and cultural context, such as temples, mosques, schools, sub-district health promotion hospitals, and learning centers.

(3) Respite Care: This service supports caregivers of disabled individuals by allowing the primary caregivers or family members to take a break. It can be formal or informal and can take place either in-home or outside the home (European Union Agency for Fundamental Rights, 2017).

(4) Information Support: This service involves assistance from others close to the disabled individual and their family, such as relatives, friends, and community disability groups.

(5) Voluntary Support: In Thailand, this includes services provided by volunteers from organizations such as the Social Development and Human Security Volunteers (SDHSV) or various types of volunteers. These volunteers undergo training courses on caring for different types of disabilities and participate in community social services to help disabled individuals access community services.

(6) CPR Centers (Suffering Relief and Happiness Promotion Project): Thailand has established this project, managed by the Department of Protection and Development of Disabled Persons, to expand proactive care roles for disabled individuals and strengthen the ability of families or communities to care for disabled individuals without needing to send them to protection and development centers (Tunyaluk Roongsangjun, 2020, p. 105).

Both concepts of care for disabled individuals should develop their models and operational guidelines together, as the number of registered disabled individuals is increasing. Additionally, disabled individuals not receiving care in childhood may experience increased disability, and rehabilitation as they age will take longer to restore normalcy and self-reliance (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019). Therefore, preventing disability and promoting care for disabled individuals outside institutions are crucial for all types of disabilities. Social service arrangements for disabled individuals must align with their needs.

From the concept of care for disabled individuals, two models of care can be identified: 1) Institutionalization and 2) Deinstitutionalization, as shown in Table 2.2.

Table 2.2 Forms of Welfare Protection for Disabled Individuals in Institutions and Outside Institutions

Service Provision for People with Disabilities	**In Stitutional**	**Outside Institutional**
1. Concept	- Rights of persons with disabilities - Assistance - Social welfare	- Rights of persons with disabilities - Independent living - Social welfare
2. Service model	- Protection - Formal care	- Empowerment - Social support - Informal care
3. Characteristics of service	- Services provided based on type of disability, age, and severity of disability with consideration for self-help abilities	- Services provided according to type of service such as counseling, employment support, residential assistance, livelihood support, and daily living services
4. Accommodation	- Services provided within defined boundaries and	- Freedom and privacy within the resident's area, able to

Service Provision for People with Disabilities	**In Stitutional**	**Outside Institutional**
	regulations, unable to make decisions or manage personal space independently - Coexisting with other disabled persons based on disability type or age as organized by the service provider, with cramped conditions - Entry and exit from residential accommodations according to facility regulations	manage space according to personal needs - Living with family, relatives, foster families, caregivers, or independently with other disabled individuals - Able to determine own entry and exit times from residential accommodations
5. Health	- Health care provided within the institution as per institution’s healthcare program	- Health care provided as per disability rights specified by each country
6. Education	- Education provided according to disability type and age range as specified by the service provider	- Receives basic education according to rights and able to make educational decisions as desired
7. Employment	- Skills training and readiness preparation for work provided according to program arrangements - Suitable job placement according to abilities and in	- Skills training and readiness preparation for work provided - Suitable job placement according to abilities

Service Provision for People with Disabilities	In Stitutional	Outside Institutional
	accordance with agreements/coordinated efforts between service providers and employers	
8. Social inclusion	- Lack of opportunities for political and social participation	- Able to independently decide to participate in political and social activities
9. Caregiver	- Caregivers provided in proportion to institution's regulations	- May or may not have caregivers and can choose caregivers
10. Service options	- Service providers act as controllers and organizers of service programs according to appropriateness	- Service users are in control and have options for various services

Source: Rapeepan Kumhom and Tunyaluk Roongsangjun (2019, pp. 84-85).

There are two forms of care for people with disabilities: 1) Institutionalization, which is care provided by state agencies such as the Department of Empowerment of Persons with Disabilities and the Occupational Skills Development Centers, and 2) Deinstitutionalization, which includes family-based care and community-based care. (Tunyaluk Roongsangjun, 2020)

Family-based care for people with disabilities often leads to better physical and emotional well-being compared to institutional care. However, some Thai families view caring for people with disabilities as the responsibility of state agencies and may lack the knowledge and resources to provide adequate care, leading them to place their disabled family members in state care facilities. (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019)

For Thailand, the family is considered an essential social institution. “Care, support, promotion, and encouragement from family and community will improve the physical, mental, spiritual, and social health of persons with disabilities” (Ratchanee Sansern et al., 2013, p. 27). The family serves as a fundamental base for caring for persons with disabilities, providing care through individuals who have close relationships, emotional bonds, and blood ties. However, issues can arise in the family care of persons with disabilities. Current problems include inadequate care from some families, lack of confidence in caregiving, poverty, lack of necessary equipment for care, violence against persons with disabilities, confinement, neglect, exploitation, and some families viewing the care of persons with disabilities as a state responsibility, thus sending them to shelters. Studies on the development of care models and management in institutions by the Department of Welfare Protection and Development for Persons with Disabilities by Rapeepan Kumhom and Tunyaluk Roongsangjun (2019) found that many persons with disabilities experience stress, loneliness, depression, reduced or no food intake, and adaptation issues leading to physical and mental illnesses when placed under the care of state-run disability care facilities or shelters.

The concepts and models of care for persons with disabilities indicate that those who cannot care for themselves or have limited self-care abilities need caregivers. Caregivers refer to family members of persons with disabilities or other individuals who take responsibility for the care or support of persons with disabilities by: 1) assisting, caring for, and encouraging persons with disabilities to be as self-reliant as possible in daily life; 2) preventing or reducing the risk of complications from disabilities; 3) providing motivation, advice, and encouragement to help persons with disabilities overcome obstacles; and 4) offering basic information on various aspects, including social, environmental, and health, to improve the quality of life for persons with disabilities (Khlong Daen Subdistrict Administrative Organization, 2020). The system of care for persons with disabilities must be holistic, integrated, and comprehensive across all dimensions of care, including health promotion, complication prevention, treatment, and rehabilitation (Ratchanee Sansoen et al., 2013).

2.2.4 The Concept of Innovative Caregiving

World Health Organization (2018) has developed the concept of innovative care for chronic conditions (ICCC) by defining a framework for caring for individuals with chronic conditions. It states that caring for chronic conditions involves interactions within a concentric structure, surrounded by 3 systems: the micro system, the meso system, and the macro system. This can be applied to caring for people with disabilities, with the central focus being on the individual with chronic conditions or disabilities, their family, community members, and the health team involved in care. The micro system involves interactions between the individual with chronic conditions or disabilities, their family, community members, and the health team, providing information, motivation, and preparedness (Akanit Chatkitanan et al., 2014). The involvement and support received from the micro system are then linked to the meso system, which is divided into health service units and communities (Jirawat Thewawatpakorn et al., 2021).

Health care organizations play a supporting role in ensuring that the healthcare team can perform at their best when connected with community stakeholders, patients, individuals with disabilities, and their families, resulting in positive outcomes. The roles of health care organizations include: 1) Promoting continuity and collaboration by coordinating cooperation among caregivers and healthcare workers at the primary, secondary, and tertiary levels, gathering knowledge, information, and skills from various groups of healthcare workers, and designating a care coordinator to control and ensure direct care outcomes. 2) Creating skilled health care teams by establishing teams comprised of healthcare professionals who work collaboratively and share responsibility, possessing knowledge and specialized skills to support continuous behavioral change, accepting their roles and responsibilities within the team, and adjusting care approaches. 3) Supporting self-management and prevention by providing patients, individuals with disabilities, and caregivers with information, motivation, and support for self-care practices in daily life and prevention of disease symptoms. 4) Promoting the use of information systems by collecting and managing data related to outbreaks, treatments, and care outcomes with the goal of planning care plans, monitoring treatment progress, and assessing care outcomes through information systems. 5) Encouraging quality through leadership and rewards, where leaders play a significant role in continuous. (Jirawat Thewawatpakorn et al., 2021)

Community Communities are essential in healthcare and chronic disease management. Their roles include: 1) Building Awareness and Reducing Stigma: Community leaders must raise awareness about diseases, illnesses, and related factors within the community. This involves political actions to garner support for healthcare. 2) Stimulating Positive Outcomes through Leadership: Supporting local leaders and international organizations such as NGOs is crucial. Community development groups, health committees, or village development groups assist in raising awareness about chronic diseases and associated risk factors, aiming for improved care through clear healthcare policies. 3) Driving and Integrating Resources: Community leaders from local and national-level organizations (NGOs) and women’s groups are vital in fundraising efforts. This supports screening, prevention, and enhancing the efficiency of chronic disease management. 4) Supporting Necessary Collaborative Services: Local health and community service units must collaborate effectively to prepare for managing and preventing health issues related to chronic diseases in the community. This includes providing self-care education, risk management, and basic disease service skills training. These efforts, coupled with clear policies and efficient support systems, significantly enhance community healthcare and chronic disease management outcomes (Rachanee Sunsern et al., 2012).

2.2.5 Care for Persons with Disabilities

Family care for persons with disabilities involves physical, emotional, and rights and welfare aspects that vary significantly (Sirindhorn National Medical Rehabilitation Institute, 2015). The methods for caring for persons with disabilities include:

2.2.5.1 Visual Impairments

1) Visual impairments are categorized into two groups based on the level of vision impairment, determined by visual acuity and field of vision. This categorization results in two types of impairments: 1. Low vision, and 2. Blindness. The characteristics and impairments are detailed in Table 2.3.

Table 2.3 Assessment of Visual Acuity, Field of Vision, and Characteristics of Visual Impairments in Persons with Visual Disabilities

Considering Visual Acuity	**Considering Peripheral Vision**	**Characteristics of Disability**
Worse than 6/18 meters or 20/70 feet, but can still read at 3/60 meters or 20/400 feet.	Narrower than 30 degrees to 10 degrees.	Blurred vision
Worse than 3/60 meters or 20/400 feet up to blindness, even with bright light.	Narrower than 10 degrees to 0 degrees.	Blindness

Source: Sirindhorn National Medical Rehabilitation Institute (2015, p. 1).

Causes of visual impairments include genetic disorders, infectious diseases affecting vision, brain disorders causing abnormal vision, congenital disabilities, accidents, and others.

2) Methods of Care: Care is tailored according to the severity and nature of the visual impairment as follows:

(1) Low vision: Assistance in daily activities such as bathing, face washing, hair washing, tooth brushing, eating, and toileting. Provision of assistive devices such as white canes or blind canes, eyeglasses, electronic visual aids (e.g., CCTV for reading and writing), telescopes (monocular and binocular) for near and distance vision (up to infinity), and night walking aids for those with low vision. Utilization of programs and apps like Claro MagX, Magnifying Glass Free, Magnifier, and Hand Glass. Environmental adjustments for individuals with low vision.

(2) Blindness: Care and training in daily activities such as bathing, face washing, hair washing, tooth brushing, eating, and dressing. Mobility training including walking, chair sitting, floor positioning, directional orientation, guiding techniques (elbow guiding), stair climbing, maneuvering through narrow passages, entering and exiting doors, boarding public transport, use of assistive

devices and technologies for the blind, tactile aids, auditory aids, white cane usage, and environmental adjustments for individuals with visual disabilities.

Furthermore, support for individuals with visual impairments includes medical services, education, and vocational training. Care approaches vary depending on the nature and severity of each individual's visual impairment.

2.2.5.2 Hearing Impairment or Communication Impairment

Characteristics of disability and impairment: Hearing impairment refers to abnormalities in a child's hearing that occur from the time of conception, including those inherited genetically or resulting from abnormalities during the prenatal, perinatal, and postnatal periods. Hearing impairments in adults involve either the loss of hearing ability or defects in the auditory structures or systems that impact daily communication. These impairments are categorized by levels of hearing and listening abilities, as shown in Table 2.4.

Table 2.4 Levels of Hearing and Listening Abilities of Individuals with Hearing or Communication Impairments

Hearing Level	**Listening Ability**
Normal hearing (below 25 decibels)	No difficulty understanding language or hearing soft sounds.
Mild hearing loss (26-40 decibels)	Difficulty hearing soft or distant sounds or speech from afar.
Moderate hearing loss (41-55 decibels)	Able to understand conversation within 3-5 feet.
Moderately severe hearing loss (56-70 decibels)	Difficulty understanding normal conversation; louder speech needed to comprehend.
Severe hearing loss (71-90 decibels)	May hear shouts within 1 foot but not understand.
Profound hearing loss (90 decibels and above)	Unable to hear shouts.

Source: Sirindhorn National Medical Rehabilitation Institute (2015, p. 2).

2) Care Methods: Caregivers must attend to communication needs to ensure that individuals with disabilities and those around them understand the disabled person’s needs. This involves training in sign language, lip reading, and understanding the meaning of various objects. Medical care includes monitoring ear and other bodily health, while psychological care addresses potential stress, fear, anxiety, frustration due to communication challenges, low self-esteem, and social relationships, such as interactions with peers, neighbors, community, school, and workplace.

2.2.5.3 Physical Impairment or Mobility Impairment

1) Characteristics of disability and impairment: Physical or mobility impairment refers to limitations or loss of ability in body parts such as hands, feet, arms, or legs, affecting daily activities like eating, dressing, and personal health care. Mobility limitations include inability to turn over, bedridden, or constant wheelchair use due to walking difficulties, often caused by conditions like stroke, spinal cord injuries at the neck, chest, or back, limb loss, or chronic illnesses impacting hand, foot, arm movement.

2) Care Methods: Caregivers, including parents, spouses, relatives, or other caregivers, assist with daily routines like bathing, brushing teeth, hair care, nail trimming, and toileting. They stimulate independence in daily activities to reduce caregiver burden and prevent complications. Physical therapy, joint management, exercise, walking training, wound care, positioning, appropriate nutrition, medication administration, scheduled medical visits, and adjusting home environments to suit disabilities are essential. Emotional support involves encouragement and empowerment to overcome disability-related challenges and barriers, increasing acceptance and providing basic disability rights information. Referral to relevant disability-related services aids in physical, mental, and social aspects, enhancing the quality of life for individuals with disabilities.

2.2.5.4 Psychological Impairment or Behavioral Impairment

1) Characteristics of disability and impairment: This refers to limitations in daily life activities or social participation due to psychological or brain-related impairments affecting perception, emotions, or thinking.

People with psychosocial impairment are those who experience physical and mental disability, hindering their ability to care for themselves in daily activities, learning, occupational pursuits, and social relationships. This impairment may stem from significant psychiatric disorders such as chronic illnesses, dementia, brain damage, abnormal brain function, substance abuse, brain vascular disorders, and nervous system diseases. Psychiatric disorders such as schizophrenia, paranoia, bipolar disorder, and depression affect thinking, emotion perception, and behavior, constituting chronic illnesses with recurring episodes. Major impacts include functional decline, incapacity, or disability, requiring assistance from others and often resulting in societal stigma, reduced self-esteem, lack of confidence, and social exclusion.

2) Care Methods: Caregivers must provide consistent medical care, regular medical visits, medication adherence, electroconvulsive therapy, and counseling (consulting psychiatrists, psychologists, and social workers). Home rehabilitation efforts should stimulate self-care development, household living, leisure activities, occupational skills, social integration, trust-building, encouragement, respect, and praise for achievements or successes. Effective management during exacerbations or relapses is crucial.

2.2.5.5 Intellectual Disability

1) Characteristics and Impairments: Intellectual disability refers to developmental impairments that limit intellectual functioning, learning, and adaptation in daily life. The term “intellectual disability” is preferred over “mental retardation” and includes delayed physical, emotional, social, language, and intellectual development compared to typical children. The severity of intellectual disabilities can be categorized into levels: severe, moderate, mild, and borderline. Each level involves impairments in motor skills, communication, psychiatric abnormalities, seizures, and sensory impairments (such as deafness, blindness, strabismus, and abnormal eye movements).

2) Care Methods: Caregivers must attend to daily routines such as bathing, facial cleansing, bathing, brushing teeth, bowel movements, and dressing, as individuals with intellectual disabilities often have minimal self-care abilities. Additionally, there may be impairments in vision, speech, swallowing, turning,

sitting, concentration, folding, and decision-making. Apart from routine care, stimulating developmental activities tailored to their specific impairments in physical, emotional, and intellectual domains are necessary. Each individual with intellectual disabilities exhibits unique variations in severity across physical, emotional, and intellectual impairments, necessitating personalized care.

2.2.5.6 Learning Disabilities

1) Characteristics and Impairments: General learning disabilities refer to individuals with normal or potentially above-average intellectual abilities but with specific impairments in learning processes such as reading, writing, and arithmetic, or other basic learning processes. These impairments may affect one or more areas, leading to lower academic performance than expected. This type of disability is more prevalent in males, with a ratio of up to 4:1 compared to females. Additionally, learning disabilities encompass difficulties in reading comprehension, spelling, writing, arithmetic, or may include other associated problems such as communication difficulties (slow speech, speech impediments, limited vocabulary), short attention span, visual perception issues, motor coordination and movement disorders (poor coordination), and behavioral issues (withdrawal, aggression, social isolation).

2) Care Methods: Medical and educational care is essential, involving physicians, nurses, rehabilitation therapists, teachers, and caregivers. Caregivers play a direct role in daily routines such as bathing, facial cleansing, hair washing, tooth brushing, bowel movements, and dressing. They also focus on stimulating development in communication skills (listening, speaking, reading, writing), language use, learning, arithmetic, muscle training (grasping objects, using pens and utensils), sitting, walking, and lying down.

2.2.5.7 Autism

1) Characteristics and Impairments: Autism is a developmental disorder characterized by specific patterns of impairment in children. These impairments are prominently observed in three main areas: (1) Social interaction and relationships with others, (2) Language and communication skills, and (3) Behavioral abnormalities and interests. Children with autism tend to isolate themselves in their own world, as if there is an invisible wall separating them from the surrounding social

environment. This isolation hinders their perception and ability to learn from their surroundings, unlike typically developing children of the same age. Symptoms often manifest before the age of 3 and are more prevalent in males than females. Autism has been recognized for over 60 years, yet clear causes remain unidentified.

2) Care Methods: Comprehensive care for individuals with autism includes:

(1) Developmental stimulation: Daily routine care such as handwashing, tooth brushing, bathing, drying, using the bathroom, and dressing. Learning must be repetitive and gradually progressed based on real-life situations and visuals.

(2) Basic skill development: Focusing on learning and behavioral adjustments such as eye contact, attention control, emotional regulation, listening, and following instructions. It’s crucial as individuals with autism struggle with eye contact, cannot sit still, lack attention, and have difficulty controlling their emotions. Therefore, caregiving prioritizes these aspects to ensure safety from accidents and misunderstandings with others.

(3) Social skill development: Encouraging interaction with others is vital as individuals with autism tend to have a private world, prefer solitary play, speak to themselves, and struggle with understanding and expressing emotions. Caregivers help integrate them into social activities, encouraging interaction with family members, peers, and community members through group activities and outings.

(4) Communication skill development: Individuals with autism often struggle with language learning, communication, and speech clarity, such as speaking slowly, repeating words, speaking alone, or being non-verbal. Effective communication is critical for understanding others and conveying their own needs and knowledge. Difficulty in communication can lead to stress, anxiety, aggression, and withdrawal.

Therefore, individuals with autism will exhibit specific disabilities and abnormalities starting from their developmental stages, making it difficult for them to independently manage daily routines. They may have speech and communication difficulties, leading to misunderstandings with others and an inability to express their needs and knowledge. They may not understand language, have difficulty listening and comprehending, fail to follow instructions, and may not know their own or others' names. They may avoid eye contact, live in their own world, and struggle with social interactions. Thus, proper care is crucial to ensure a good quality of life, physical and emotional well-being, and the ability to live harmoniously with others in the community and society (Sirindhorn National Medical Rehabilitation Institute, 2015).

From the above caregiving methods for individuals with disabilities, it is evident that each type of disability requires different caregiving approaches based on its characteristics and limitations. Additionally, family and community support are crucial and should not be overlooked. Families must actively engage in activities, greet others, and build relationships with neighbors and communities. This involvement allows neighbors and communities to serve as internal resources or social networks to effectively assist people with disabilities and their families. This includes providing care, purchasing goods, sharing information, assisting during illnesses, and physically supporting individuals with disabilities.

2.2.6 Rights of Persons with Disabilities and Benefits for Caregivers

In addition to the concepts, forms, and methods of caring for persons with disabilities, there are rights for persons with disabilities and benefits that caregivers receive from caring for persons with disabilities, according to the Rights of Persons with Disabilities Act (2021), as follows:

2.2.6.1 Rights of Persons with Disabilities

1) Issuance of disability identification cards.

2) Disability allowance of 800 Baht per month.

3) Access to vocational rehabilitation loans, up to 40,000 Baht per individual and up to 1,000,000 Baht per group, with repayment over a maximum of 5 years.

4) Social welfare and protection rights for persons with disabilities.

5) Housing environment adaptation rights for persons with disabilities, subsidized up to 20,000 Baht.

6) Accessibility rights, including access to BTS, MRT, and public buses.

7) Medical rights, allowing free medical treatment.

8) Rehabilitation rights through medical procedures and assistive devices.

9) Education rights, with exemption from education fees from initial enrollment to bachelor’s degree level, along with access to accessible technologies, media, services, and other educational assistance, ensuring standardized and quality education. Responsible agencies are required to provide comprehensive support for accessibility services, media services, and any other educational assistance necessary for persons with disabilities.

10) Vocational promotion and protection of employment rights for persons with disabilities, including vocational funds.

2.2.6.2 Benefits for Caregivers of Persons with Disabilities

Caregivers of persons with disabilities are entitled to various forms of assistance as specified by the Department of Empowerment of Persons with Disabilities (2021), including:

1) Counseling and guidance services.

2) Training in caregiving skills to meet academic and professional standards.

3) Education management to promote learning and skill development for enhancing the quality of life of persons with disabilities.

4) Promotion of independent vocational skills.

5) Employment opportunities within enterprises.

6) Vocational training.

7) Financial support for vocational funds, including loans from the Fund for the Promotion and Development of Quality of Life for Persons with Disabilities (applicable to caregivers of persons with intellectual, mental, or behavioral disabilities).

8) Provision of demonstrations or retail venues.

9) Contract employment and other forms of support.

10) Personal income tax deductions.

11) Other assistance aimed at promoting and developing the quality of life of persons with disabilities.

In addition, persons with severe disabilities also have the right to apply for the service of a Personal Assistant (PA), provided by the government for those who critically need assistance to perform daily activities and live independently. The goal is to enable severely disabled individuals to live with dignity, value, and improved quality of life (Department of Empowerment of Persons with Disabilities, 2021).

Therefore, it can be concluded that persons with disabilities have rights in terms of health, finances, education, housing, environment, transportation, and rehabilitation, ensuring equal protection as other individuals. According to the principle of equality for persons with disabilities, they should have choices similar to others. Services and facilities that meet the needs of persons with disabilities should be provided equally to others (United Nations, 2007). Caregivers of persons with disabilities also have rights and benefits in terms of consultation, caregiving knowledge, vocational support, tax exemptions, and necessary assistance to promote and support the care of persons with disabilities, thereby alleviating the burden on caregivers (Rajanukul Institute, 2023). Therefore, persons with disabilities are individuals who may have abnormalities or impairments, but with support from family or physical accommodations, these can mitigate existing disabilities and not result in a disadvantage in their lives (Kanitta Thewintharaphak, 2012).

2.3 International Rules, Regulations, and Policies Related to Persons with Disabilities

2.3.1 International Human Rights Covenant

Persons with disabilities are an important population group that should receive equal treatment as other populations, especially regarding human rights such as education, employment, healthcare, and welfare.

Thailand is among the first 48 countries to vote to endorse this covenant. Human rights emphasize equality in humanity, including persons with disabilities (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019). There are 30 points in detail, with key points relevant to persons with disabilities. For example, Article 1: "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." And Article 25 (1): "Everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond their control" (United Nations, 2015).

In addition to these two fundamental points, other human rights in various articles help promote equality and non-discrimination, ensuring no obstacles prevent individuals, including persons with disabilities, from accessing rights and protections that differ (United Nations, 2007).

2.3.2 UN Convention on the Rights of Persons with Disabilities

Thailand became a party to this convention on July 29, 2008. The convention aims to promote the protection and ensure persons with disabilities have access to all human rights and fundamental freedoms equally and without discrimination, and promote respect for inherent dignity (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019). The convention emphasizes the rights of persons with disabilities, as shown in Table 2.5

Table 2.5 Dimensions and Implementation Measures Related to the Rights of Persons with Disabilities

Dimension	Implementation of Measures
Personal mobility	The state has implemented effective measures to ensure the maximum possible independent mobility for persons with disabilities, including: (a) Providing convenience in personal mobility options that are suitable in terms of type and timing, and at prices that individuals with disabilities can afford. (b) Facilitating access to mobility aids, tools, technologies,

Dimension	Implementation of Measures
	living organisms, and media in forms that are both living and supportive, ensuring they are available at prices that individuals with disabilities can afford. (c) Providing training in mobility skills for both persons with disabilities and specialized personnel working with them. (d) Supporting organizations that produce mobility aids, tools, technologies, and various conveniences, considering all aspects of mobility for persons with disabilities.
Freedom of expression and opinion, and access to information	The state has implemented appropriate measures to ensure that persons with disabilities can exercise their rights to freedom of expression and opinion, including the freedom to seek, receive, and impart information and ideas on an equal basis with others, through various communication formats chosen by persons with disabilities. This includes: (a) Providing information for the general public to persons with disabilities in accessible formats and technologies suitable for their disabilities, within a reasonable timeframe and at no additional cost. (b) Recognizing and facilitating the use of sign language, braille, alternative and augmentative communication methods, and various communication channels, allowing persons with disabilities to interact with government agencies. (c) Encouraging private sector organizations that provide services to the public, including internet-based services, to ensure that information and services are accessible and beneficial to persons with disabilities. (d) Supporting mass media and internet service providers in making their services accessible to persons with disabilities. (e) Acknowledging and promoting the use of sign language.

Dimension	Implementation of Measures
Respect for privacy	1. Persons with disabilities, regardless of their living arrangements or housing conditions, have the right to be free from interference in their privacy, family, home, or correspondence, whether by unlawful attacks on their honor and reputation or by any unlawful means. Persons with disabilities have the right to legal protection against such interference or unlawful attacks. 2.The state should protect the privacy of personal information, health-related data, and rehabilitation progress of persons with disabilities on an equal basis with others.
Respect in family and family institutions	1. The state shall implement effective and appropriate measures to eliminate discrimination against persons with disabilities in all aspects related to marriage, family, parenthood, and relationships, based on equality with others, ensuring that: (a) Persons with disabilities have the right to marry and establish a family on the basis of free and full consent of the intending parties. (b) Persons with disabilities have the right to make decisions freely and responsibly regarding the number and spacing of children, and to access appropriate information about reproductive health and family planning. They should be supported with methods to exercise these rights. (c) Persons with disabilities, including children with disabilities, retain their reproductive rights on an equal basis with others.

Dimension	Implementation of Measures
	2. The state shall guarantee the rights and responsibilities of persons with disabilities in matters of child-rearing, child protection, custody arrangements, and adoption, or similar arrangements. These principles are enshrined in law, and in all cases, the best interests of the child shall be the paramount consideration. The state shall provide appropriate assistance to persons with disabilities in fulfilling their responsibilities for child care. 3. The state shall ensure that children with disabilities have equal rights to family life. To ensure the realization of these rights and prevent concealment, abandonment, neglect, or separation of children with disabilities from their families, the state shall provide comprehensive information, services, and support from the outset to children with disabilities and their families. 4.The state shall ensure that children shall not be separated from their parents against their will, except when competent authorities determine, in accordance with applicable laws and procedures, that such separation is necessary for the best interests of the child. Such determinations may be subject to review by a court. Under no circumstances shall a child be separated from their parents due to disability-related reasons of the child, parent, or both parents. 5.In cases where close-knit families are unable to care for a child with disabilities, the state shall make every effort to ensure that the child receives alternative care within an expanded family setting. If this is not feasible, the child shall

Dimension	Implementation of Measures
	receive community-based family-like care within the community where the child resides.
Education	1.The state acknowledges the right of persons with disabilities in education and ensures their effective use without discrimination, based on equal opportunities. The state guarantees inclusive education at all levels and lifelong learning aimed at: (a) Developing human potential and fostering self-esteem and dignity, promoting respect for human rights, fundamental freedoms, and diversity. (b) Enabling persons with disabilities to develop their personal abilities, talents, and creative thinking, including mental and physical capacities, to their fullest potential. (c) Allowing persons with disabilities to actively participate in society in a meaningful way. 2. To ensure the realization of these rights: (a) Persons with disabilities shall not be excluded from mainstream education systems due to their disabilities. Children with disabilities shall not be segregated from compulsory primary education and shall have access to secondary education without any cost. (b) Persons with disabilities shall have access to quality inclusive education at primary and secondary levels, on an equal basis with others in the community they reside in. (c) Persons with disabilities shall receive appropriate assistance tailored to their individual needs. (d) Persons with disabilities shall receive necessary support in general education systems to facilitate effective learning

Dimension	Implementation of Measures
	experiences tailored to their needs. (e) Specific measures shall be implemented to effectively support persons with disabilities in academic and social development within inclusive environments that aim for full participation in society. 3. The state shall implement measures to enable persons with disabilities to acquire life skills and social skills for full and equal participation in education and community membership, including: (a) Promoting braille literacy, alternative forms of communication, and promoting familiarity with environments and mobility. Promoting peer support systems and mentoring. (b) Promoting sign language learning and supporting the linguistic identity of the deaf community. (c) Ensuring that education for individuals, especially blind, deaf, or deafblind persons, has the most appropriate language and communication methods tailored to each individual. 4. Ensuring the environment promotes maximum academic and social development. To ensure effective use of these rights: The state shall implement appropriate measures to hire teachers, including qualified teachers proficient in sign language and/or braille. Training professionals and staff at all levels of education shall include awareness of disabilities and the use of appropriate communication channels, methods, and supportive techniques for teaching and supporting persons with disabilities. 5. The state shall ensure that persons with disabilities have

Dimension	Implementation of Measures
	access to general education at the tertiary level, vocational training, adult education, and lifelong learning without discrimination and on an equal basis with others. The state guarantees appropriate assistance to persons with disabilities for these purposes.
Health	The state acknowledges that persons with disabilities have the right to the highest attainable standard of health care without discrimination based on disability. The state shall implement appropriate measures to ensure that persons with disabilities have access to health services, considering gender, including reproductive health, and public health programs available to the general population. To ensure the realization of these rights: (a) Provide health services free of charge or affordable for persons with disabilities at the same quality and standards as provided to others, including sexual and reproductive health services and public health programs. (b) Provide necessary health services for persons with disabilities, especially related to their disabilities, including appropriate early intervention and services aimed at minimizing disability and preventing further impairment, for both children and the elderly. (c) Ensure that these health services are as close as possible to the communities where persons with disabilities reside, including rural areas. (d) Ensure that medical personnel provide quality care to persons with disabilities, based on voluntary and informed consent, and informed by awareness of human rights, dignity, independent living, and the specific needs of persons with

Dimension	Implementation of Measures
	disabilities through training and adherence to ethical standards in health care provision by both public and private sectors. (e) Prohibit discrimination against persons with disabilities in health insurance and life insurance, ensuring fairness and legality in life insurance according to the laws of the state. (f) Prevent denial of health care, health services, or fluids and food by discriminatory practices against persons with disabilities.
Promotion of physical fitness and rehabilitation	1.The state shall implement effective and impactful measures, including peer support, to enable persons with disabilities to achieve and maintain maximum independence, full physical, mental, social, and vocational ability, and to fully integrate and participate in all aspects of life. To achieve this, the state shall provide comprehensive services and programs to promote capacity building and rehabilitation, especially in health care, employment, education, and social services, in a manner that is tailored to the needs and strengths of each individual, based on interdisciplinary principles. (a) Initiate actions from the earliest stages possible, based on assessments of the necessary needs and strengths of each individual by professional standards. (b) Support participation in the community and being an integral part of society in all aspects, based on the voluntary participation of persons with disabilities, and provide services as close as possible to the communities where persons with disabilities reside, including rural areas. 2. The state shall promote the development of initial and ongoing training for professionals and staff working in

Dimension	Implementation of Measures
	disability services to enhance the capabilities and rehabilitation of persons with disabilities. 3. The state shall promote the provision of knowledge, equipment, and assistive technology specifically designed for persons with disabilities related to capacity building and rehabilitation.
Employment and hiring”	1. The state acknowledges the rights of persons with disabilities to work on an equal basis with others, including the right to earn a livelihood through freely chosen or accepted work in the open labor market and work environments that are inclusive and accessible. The state shall protect and promote the exercise of these rights, including for persons who acquire disabilities during employment, by conducting appropriate processes, including legal measures, particularly: (a) Prohibiting discriminatory practices due to disability in all aspects of employment, including criteria for selection and hiring, continuous career advancement, and ensuring occupational health and safety. (b) Ensuring the protection of the rights of persons with disabilities on an equal basis with others in fair working conditions and benefits for persons with disabilities, including equal opportunities and equal pay for equal work, occupational safety, and health, protection from harassment, and handling of complaints. (c) Ensuring that persons with disabilities can exercise labor rights and join labor unions on an equal basis with others. (d) Facilitating access for persons with disabilities to vocational guidance, general counseling services, job

Dimension	Implementation of Measures
	placement, and continuous vocational training effectively. (e) Promoting job opportunities and career advancement for persons with disabilities in the labor market, including assistance in job search, job retention, and return to work. (f) Promoting opportunities for self-employment, entrepreneurship, and cooperative development for persons with disabilities. (g) Ensuring employment of persons with disabilities in public sector agencies. (h) Promoting employment of persons with disabilities in private sector agencies through appropriate policies and measures, including positive incentive programs and other measures. (i) Ensuring effective assistance to persons with disabilities in the workplace. (j) Promoting work experiences for persons with disabilities in open labor markets. (k) Promoting vocational and professional rehabilitation programs, job retention, and return to work for persons with disabilities. 2. The state guarantees that persons with disabilities shall not be subjected to slavery or servitude-like conditions and shall receive protection on an equal basis with others from coerced or forced labor.
Adequate standards of living and social protection	1.The state recognizes the rights of persons with disabilities to a standard of living adequate for themselves and their families, including food, clothing, and adequate housing, as well as continuous improvement of living conditions. The state shall

Dimension	Implementation of Measures
	take appropriate steps to ensure and promote these rights without discrimination based on disability. 2.The state acknowledges the rights of persons with disabilities to social protection and to enjoy these rights without discrimination based on disability. The state shall take steps to protect and promote these rights, including: (a) Ensuring equal access to clean water services and access to various equipment and other necessary assistance related to disabilities that are appropriate and affordable. (b) Ensuring access to social protection programs and poverty reduction programs for persons with disabilities, particularly focusing on disabled women, girls, and elderly persons. (c) Ensuring access to state assistance for expenses related to disabilities, including adequate training, financial counseling, and temporary care, for persons with disabilities and families facing financial difficulties. (d) Ensuring access to state welfare housing programs for persons with disabilities. (e) Ensuring access to programs and benefits after retirement age for persons with disabilities equally.
Political and public participation	1. Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, whether directly or through freely chosen representatives, including: (a) Ensuring accessible voting processes, facilities, and materials that are appropriate, understandable, and easy to use. (b) Protecting the rights of persons with disabilities to vote independently in elections and referendums, free from

Dimension	Implementation of Measures
	intimidation, and ensuring their ability to stand for election and hold office at all levels of government, with appropriate access to assistive devices and new disability-friendly technologies as needed. (c) Recognizing the freedom of persons with disabilities to express their political opinions and, where necessary, allowing them to be assisted by a person of their choice when voting. 2. Promote an enabling environment where persons with disabilities can effectively participate in public activities without discrimination, on an equal basis with others, and stimulate participation in public affairs, including: (a) Participation in non-governmental organizations and associations working in public and political sectors within the country, including involvement in activities and management of political parties.
Cultural participation, recreation, leisure, and sports	1. The state acknowledges the rights of persons with disabilities to participate in cultural activities on an equal basis with others. The state shall implement appropriate measures to ensure that persons with disabilities: (a) Have access to cultural materials in accessible formats. (b) Have access to cultural programs such as television, movies, dramas, and other cultural activities in accessible formats. (c) Have access to cultural venues and services, such as theaters, museums, cinemas, libraries, and tourist facilities, to the extent feasible, including access to national monuments and culturally significant sites. 2. The state shall implement appropriate measures to enable

Dimension	Implementation of Measures
	persons with disabilities to develop and utilize their creative potential in arts and intellectual fields, not only for their personal benefit but also to enhance societal value. 3.The state shall take appropriate steps, in line with international law, to ensure that intellectual property laws do not unjustly restrict access to cultural materials by persons with disabilities. 4. Persons with disabilities have the right to be recognized and promoted in their cultural and linguistic identities, including sign languages and the cultural identity of Deaf people, on an equal basis with others. 5. To ensure that persons with disabilities can participate on an equal basis with others in recreational, leisure, and sports activities, the state shall implement appropriate measures, including: (a) Stimulating and promoting the maximum possible participation of persons with disabilities in general sports activities at all levels. (b) Ensuring opportunities for development and participation in sports and recreational activities specific to each type of disability, and promoting teaching, training, and appropriate resources on an equal basis with others. (c) Ensuring access for persons with disabilities to sports, recreational, and tourist facilities. (d) Ensuring that children with disabilities have equal access to play, recreational activities, leisure time, and sports, including within the school system.

Dimension	Implementation of Measures
	(e) Ensuring access for persons with disabilities to services provided by relevant personnel in organizing recreational, tourist, leisure, and sports activities.

Source: Rapeepan Kumhom and Tunyaluk Roongsangjun (2020, pp. 8-15).

Families should be promoted and supported to provide standardized and comprehensive care for persons with disabilities in accordance with international human rights conventions and conventions on the rights of persons with disabilities (Rapeepan Kumhom & Wannawadee Poolphoksin, 2019). This is to ensure that persons with disabilities have a good quality of life in terms of physical, mental, and social well-being, supported by families, which are fundamental institutions with close and strong relationships in caregiving (Department of Empowerment of Persons with Disabilities, 2021).

2.3.3 Incheon Strategy to “Make the Right Real for Persons with Disabilities in Asia and the Pacific

The Incheon Strategy “Making the Right Real” has been endorsed at the High-level Intergovernmental Meeting on the Asian and Pacific Decade of Persons with Disabilities, under the framework of the Economic and Social Commission for Asia and the Pacific (ESCAP), held in Incheon, Republic of Korea. This strategy, rooted in the Convention on the Rights of Persons with Disabilities and operational frameworks, is based on disability rights in the Asia-Pacific region. The strategy is set to conclude in 2021. At its core, the Incheon Strategy emphasizes national-level cooperation mechanisms for persons with disabilities, with interconnected agencies within each country driving its implementation forward.

The objectives and goals of the Inclusion Strategy are as follows: 1. Reduce poverty and expand opportunities for employment and hiring. 2. Promote participation in political processes and decision-making. 3.Promote access to physical environments, public transportation, knowledge, information, and communication. 4.

Strengthen social protection systems. 5.Expand early assistance and educational support for children with disabilities. 6. Ensure gender equality and empower women. 7. Ensure management and risk reduction from disasters for persons with disabilities. 8. Improve reliable and comparable disability data. 9. Accelerate institution-building and implementation of the disability rights convention. 10. Develop cooperation at regional, sub-regional, and inter-regional levels. (Department of Empowerment and Development of Persons with Disabilities, 2021) of the objectives, specific targets, and progress indicators according to Table 2.6.

Table 2.6 Objectives, Targets, Main Indicators, and Supporting Indicators According to the Inclusion Strategy

Objective	**Goals**	**Indicators of Progress**
Objective 1: Reduce poverty and expand opportunities for employment and hiring.	1. (A) Eradicate severe poverty among persons with disabilities.	Key Indicators: 1.1 Proportion of persons with disabilities living below the poverty line.
	1. (B) Increase job opportunities and employment for working-age persons with disabilities who are able and willing to work.	1.2 Employment rate of persons with disabilities compared to the general population.
	(C) Enhance the participation of persons with disabilities in vocational training programs and employment promotion plans supported by government funding.	1.3 Proportion of persons with disabilities participating in vocational training programs and employment promotion plans supported by government funding, compared to the general population participating in these programs. Supplementary Indicator:

Objective	**Goals**	**Indicators of Progress**
		1.4 Proportion of persons with disabilities living below the poverty line according to national standards.
Objective 2: Promote participation in political processes and decision-making.	2. (a) Ensure that persons with disabilities have representatives in governmental agencies responsible for decision-making.	Main Indicators 2.1 Proportion of persons with disabilities in the national legislature or equivalent national institutions. 2.2 Proportion of members participating in national cooperation mechanisms related to persons with disabilities, representing all types of disabilities. 2.3 Proportion of representatives of persons with disabilities in national mechanisms concerning gender equality and empowerment of women.
	2. (b) Provide meaningful services to promote the inclusion of persons with disabilities in political processes.	2.4 Proportion of polling stations in the capital accessible to persons with disabilities, and processes ensuring that voting is confidential. Supporting Indicators 2.5 Proportion of persons

Objective	Goals	Indicators of Progress
		with disabilities holding ministerial positions. 2.6 Proportion of persons with disabilities serving as judges in the judiciary. 2.7 Existence of rules and regulations requiring electoral authorities to develop electoral processes that facilitate access for all types of persons with disabilities.
Objective 3: Promote access to physical environments, public transportation, information, and communication.	3. (A) Enhance accessibility to public physical environments in the capital city of the country.	Main Indicators 3.1 Proportion of accessibility to buildings of government agencies in the capital city.
	3. (B) Promote access to and use of public transportation services.	3.2 Proportion of accessibility to buildings of international airports.
	3. (C) Promote access to and utilization of information and communication services.	3.3 Proportion of daily news programs on public television with closed captioning and sign language interpretation. 3.4 Proportion of accessibility to public documents and websites that meet internationally accepted standards.
	3. (D) Reduce the proportion	3.5 Proportion of persons

Objective	Goals	Indicators of Progress
	of persons with disabilities who do not have appropriate assistive devices according to their needs to half.	with disabilities who have received assistive devices according to their needs.
		Supporting Indicators 3.6 Existence of plans to assess accessibility, involving experts who are persons with disabilities. 3.7 Existence of regulations on technical standards for barrier-free accessibility in public building design and certification, based on existing international standards such as International Organization for Standardization (ISO). 3.8 Number of sign language interpreters. 3.9 Existence of regulations on technical standards for barrier-free accessibility in ICT-related services, such as public websites, based on existing international standards such as ISO.
Objective 4: Strengthen social protection.	4. (A) Enhance accessibility to all health services, including rehabilitation, for	Main Indicators 4.1 Proportion of persons with disabilities included in

Objective	Goals	Indicators of Progress
	persons with disabilities.	government-supported health care plans compared to the general population.
	4. (B) Increase the number of persons with disabilities participating in social protection programs.	4.2 Inclusion of persons with disabilities in social protection programs, including social insurance and social assistance plans.
	4. (C) Expand services and plans for social protection, including personal assistant services and peer counseling, to ensure that persons with disabilities, especially those with multiple disabilities, severe disabilities, and other types of disabilities, can live independently within their communities.	4.3 Availability of government-supported services and programs, including personal assistant services and peer counseling, to enable persons with disabilities to live independently within their communities.
		Supporting Indicators 4.4 Number of government-supported care programs for persons with disabilities, including part-time care services. 4.5 Existence of national-level plans for community-based rehabilitation. 4.6 Existence of health insurance for persons with disabilities.

Objective	Goals	Indicators of Progress
		4.7 Reduction in unmet needs for assistance and various services.
Objective 5: Expand early intervention and educational support for children with disabilities.	5. (A) Expand measures for the early detection and early intervention for children with disabilities from birth to preschool age.	Main Indicators 5.1 Number of children with disabilities receiving early intervention.
	5. (B) Halve the gap in enrollment rates between children with disabilities and non-disabled children in primary and secondary education.	5.2 Enrollment rate of children with disabilities in primary education. 5.3 Enrollment rate of children with disabilities in secondary education. Supporting Indicators 5.4 Proportion of prenatal and antenatal care facilities providing information and services on early prevention of disabilities and protection of the rights of children with disabilities. 5.5 Proportion of deaf children learning sign language. 5.6 Proportion of visually impaired students receiving accessible educational

Objective	Goals	Indicators of Progress
		materials. 5.7 Proportion of students with intellectual disabilities, developmental delays, deafness, blindness, autism, and other disabilities receiving assistive devices, curriculum adjustments, and appropriate educational materials.
Objective 6: Ensure gender equality and empower women.	6. (A) Empower girls and women with disabilities to access equal opportunities in mainstream social development. 6. (D) Increase measures to protect girls and women with disabilities from all forms of violence and abuse.	Main Indicators 6.1 Number of countries that include the promotion of participation of girls and women with disabilities in national action plans on gender equality and women's empowerment.
	6. (B) Ensure representation of women with disabilities in government agencies at decision-making levels.	6.2 Proportion of women with disabilities in the national legislature or equivalent national institutions.
	6. (C) Ensure that girls and women with disabilities have equal access to reproductive health services and sexual health as non-disabled girls and women.	6.3 Proportion of girls and women with disabilities who can access government and community-provided reproductive health and sexual health services

Objective	Goals	Indicators of Progress
		compared to non-disabled girls and women.
	6. (D) Increase measures to protect girls and women with disabilities from all forms of violence and abuse.	6.4 Number of programs initiated by the government and relevant agencies aimed at eliminating violence, including sexual abuse and exploitation, against girls and women with disabilities. 6.5 Number of programs initiated by the government and relevant agencies providing care, assistance, and rehabilitation to girls and women with disabilities who are victims of abuse and all forms of violence.
Objective 7: Ensure disaster risk management and reduction for persons with disabilities.	7. (A) Strengthen disaster risk reduction planning to include persons with disabilities.	Main Indicators 7.1 Existence of disaster risk reduction plans that include persons with disabilities.
	7. (B) Enhance measures to provide appropriate and timely assistance to persons with disabilities affected by disasters.	7.2 Training of relevant personnel to familiarize them with providing assistance to persons with disabilities affected by disasters. Supporting Indicators 7.3 Number of persons with disabilities who died or were seriously injured due to

Objective	Goals	Indicators of Progress
		disasters. 7.4 Availability of personnel who can provide mental health services to persons with disabilities affected by disasters. 7.5 Availability of assistive devices and technology for disaster preparedness and response.

Source: Rapeepan Kumhom and Tunyaluk Roongsangjun (2019, pp. 8-23).

The care of persons with disabilities by families can proceed according to Objective 4, which strengthens social protection. Objective 7 ensures management and reduces risk from disasters for persons with disabilities, while Objective 8 improves disability-related data reliability and comparability. Additionally, Objective 9 accelerates compliance with disability rights agreements and legal adjustments in the country, and the final objective enhances cooperation at the sub-regional, regional, and inter-regional levels to promote the quality of life for persons with disabilities. These efforts operate at the national policy level (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019). ultimately influencing the quality of life for persons with disabilities.

2.3.4 Bali Declaration on the Enhancement of the Role and Participation of the Persons with Disabilities in ASEAN Community

The Bali Declaration on the Enhancement of the Role and Participation of Persons with Disabilities in ASEAN Community Building, which was signed in Bali, Indonesia, by Thailand, emphasizes several crucial principles and actions related to sustainable development:

2.3.4.1 Support for ASEAN Member States: Encourage ASEAN member states to sign and ratify agreements regarding the rights of persons with disabilities and promote community-based initiatives.

2.3.4.2 ASEAN Decade of Persons with Disabilities (2011-2020): Declare the ASEAN Decade of Persons with Disabilities and related concepts to promote comprehensive development of persons with disabilities within the ASEAN community.

2.3.4.3 Establishment of ASEAN Disability Forum: Support the establishment of the ASEAN Disability Forum as a collaborative effort involving various stakeholders, including ASEAN member states, ASEAN Secretariat, intergovernmental agencies, civil society organizations, media, business sectors, academic groups, Disabled People’s Organizations (DPOs), and family organizations.

2.3.4.4 Enhancement of Quality of Life: Encourage ASEAN member states to promote the quality of life of persons with disabilities in the context of poverty alleviation and develop regional statistical indicators in ASEAN to measure the development of vulnerable groups, particularly persons with disabilities.

2.3.4.5 Confidence in Rights Achievement: Build confidence in achieving the rights of persons with disabilities in all aspects of life through the perspective of persons with disabilities in ASEAN’s economic, political security, and socio-cultural pillars.

2.3.4.6 Inclusive Development Participation: Promote the inclusive participation of persons with disabilities in all aspects of development, including political participation with equal political rights in local and national elections.

2.3.4.7 Support for Government and Civil Society Organizations: Support ASEAN governments, social organizations, and private sector development organizations to work closely with relevant ASEAN agencies on human rights and ASEAN committees on promoting and protecting the rights of women and children in joint efforts to protect and support the rights and needs of persons with disabilities, especially the elderly, women, and children.

2.3.4.8 Development of National Action Plans: Encourage ASEAN member states to develop national-level action plans on disability and allocate budgets through relevant ministries or agencies to enhance the capacity of persons with disabilities.

2.3.4.9 Facilitate Involvement in Policy Making: Facilitate convenience and support for persons with disabilities to participate in policy development, implementation, and evaluation related to disability issues.

2.3.4.10 Promote Social Services: Support ASEAN member states in promoting and disseminating social services that support persons with disabilities in social welfare and employment sectors.

2.3.4.11 Uphold Frameworks and Guidelines: Encourage ASEAN member states to expedite actions under the established frameworks of ASEAN concerning disaster management at regional and community levels.

2.3.4.12 Improve Data Sharing: Improve the sharing of best practices and experiences related to disability issues, including promoting new knowledge through research, analysis, and training.

2.3.4.13 Equal Educational Opportunities: Work towards equal educational opportunities for persons with disabilities, especially in basic education and alternative communication methods, including sign language and Braille.

2.3.4.14 Accessibility Improvements: Emphasize the necessity of providing public conveniences, public transportation, education, employment, information, technology, recreation, and sports for persons with disabilities in ASEAN.

2.3.4.15 Mainstream Disability Issues: Address core disability issues in regional and community-level disaster management policies and projects.

2.3.4.16 Social Security System Enhancement: Develop social security systems in ASEAN member states to protect severely disabled individuals, especially those with severe disabilities.

2.3.4.17 Social Inequality Reduction: Develop leadership and reduce social inequality for persons with disabilities, including developing community business networks considering gender and social inclusion.

2.3.4.18 Support International and Inter-Governmental Agencies: Support international and inter-governmental agencies to assist in implementing disability policies and projects in the ASEAN Green Paper and ASEAN Cultural Communities.

2.3.4.19 Promote Media Coverage: Promote mass media without regard to cultural sensitivity and gender in promoting accurate information and images of disabilities and persons with disabilities in ASEAN. (Rapeepan Kumhom & Wannawadee Poolphoksin, 2019).

Therefore, it can be concluded that the international conventions, laws, and strategies related to the protection of persons with disabilities, both directly and indirectly, serve as guidelines for caring for persons with disabilities from a global to regional ASEAN level. Reviewing the literature reveals that caregiving for persons with disabilities in various countries often fails to meet their fundamental rights. Specifically, family caregiving can impact the physical, emotional, mental, and social well-being of persons with disabilities. Currently, families with severely disabled members often place them in protective and developmental care facilities (disability institutions), separating them from society, which is a basic right of persons with disabilities. This action not only segregates them but also creates barriers preventing their return to mainstream society. These disability care institutions often fail to ensure safety, leaving persons with disabilities vulnerable to abuses, trafficking risks, and other issues. Moreover, they often cannot facilitate the successful integration of persons with disabilities back into society. Therefore, disability care and developmental institutions should not be the first or best option for supporting marginalized individuals or persons with disabilities.

2.4 Laws, Regulations, and Policies Related to Persons with Disabilities at the National Level

2.4.1 The Promotion and Development of the Quality of Life of Persons with Disabilities Act, B.E. 2550 (2007) Amendment (No. 2), B.E. 2556 (2013)

The Promotion and Development of the Quality of Life of Persons with Disabilities Act, B.E. 2550 (2007) Amendment (No. 2), B.E. 2556 (2013) is a significant law directly related to persons with disabilities. It includes crucial provisions concerning the rights, benefits, and protection of persons with disabilities to prevent unjust discrimination. This law categorizes disabilities into 7 types: 1) Visual impairment 2) Hearing impairment or communication impairment 3) Physical or mobility impairment 4) Mental or behavioral impairment 5) Intellectual impairment 6) Learning impairment 7) Autism

Important Provisions of the Law

This law includes key provisions related to persons with disabilities as follows:

Key Point 1: Definition of Persons with Disabilities:

Persons with disabilities are individuals who have limitations in performing activities due to impairments in vision, hearing, mobility, communication, mental or emotional functions, intellect, or learning.

Key Point 2: Framework for Rehabilitation and Promotion of Quality of Life:

Persons with disabilities receive rehabilitation to enhance their abilities and promote quality of life, including: 1) Improving the physical capabilities of persons with disabilities. 2) Promoting and developing quality of life through rehabilitation services and supporting their right to live independently, participate fully in social, economic. 3) Political activities efficiently under accessible conditions.

Key Point 3: Mechanism for Promoting and Developing Quality of Life for Persons with Disabilities:

Establishment of the National Committee for the Promotion and Development of Quality of Life for Persons with Disabilities. Provincial Committees for the Promotion and Development of Quality of Life for Persons with Disabilities. The National Office for the Promotion and Development of Quality of Life for Persons with Disabilities. Local administration to promote and develop quality of life for persons with disabilities transparently and continuously.

Key Point 4: Treatment of Persons with Disabilities:

Government agencies, private organizations, and individuals must treat persons with disabilities fairly and without discrimination.

Key Point 5: Rights Granted to Persons with Disabilities Under the Law:

Every person with a disability has the right to possess a disability identification card. Applications for disability identification cards are categorized into two types: 1) For persons with disabilities residing in Bangkok, applications can be made at the Office for the Promotion and Development of Quality of Life for Persons with Disabilities. 2) For persons with disabilities not residing in Bangkok, applications can be made at the Provincial Social Development Office responsible for human security.

In cases where the person with a disability is a minor or unable to apply personally, a parent, guardian, caretaker, or authorized representative may submit the application on their behalf. Persons with disabilities have 10 rights under the law, including:

1) Rights to Access and Utilize Public Facilities Provided by the Government, Receive Medical Rehabilitation Services, Healthcare Expenses, and Assistive Devices, Promotion of Development

2) Education Access as Appropriate

3) Vocational Rehabilitation, Labor Protection, Employment Opportunities, Ability to Pursue Independent Occupations

4) Acceptance and Full Participation in Social, Economic, and Political Activities, Receives Necessary Facilities and Services

5) Assistance in Accessing Policies, Plans, Projects, Development, and Public Services, Essential Livelihood Products

6) Communication Technology for Disabled Persons of All Types

7) Sign Language Interpreter Services

8) Rights to Use Guide Animals

9) Welfare Allowance for Disabilities

10) Adjustment of Residential Environments Provisions for Other Welfare in Accordance with Criteria and Methods Established by Committees

11) Assistance for Disabled Assistants with Reductions or Exemptions from Service Fees

12) Disabled Persons Without Caretakers Have the Right to Housing Welfare and Care from State Agencies

13) Caregivers of Disabled Persons Have the Right to Counseling, Advice, Skill Training, and Care

14) Tax Deductions or Exemptions for Caregivers of Disabled Persons

15) Private Sector Organizations Providing Benefits to Disabled Persons Entitled to Tax Deductions or Exemptions

16) Development of Quality of Life for Disabled Persons with Promotion and Development Funds for Use in Protection and Development

Employers or State Agencies Must Hire Disabled Persons in Positions Commensurate with the Nature of the Work in Proportion to the Suitable Workforce. In Cases Where Disabled Persons Are Not Employed According to the Prescribed Number, Funds Are to Be Sent to the Promotion and Development Fund for Quality of Life for Disabled Persons Instead.

Key Point 6: Safeguarding the Rights of Persons with Disabilities

This law establishes channels for verifying rights, asserting rights, and making proposals regarding the rights of persons with disabilities. It mandates that the National Committee for the Promotion and Development of Quality of Life for Persons with Disabilities reviews the entitlements received by persons with disabilities.

In cases where a government agency, private entity, or individual fails to comply with the provisions of the law concerning responsibilities towards persons with disabilities, the National Office for Empowerment of Persons with Disabilities must notify the relevant individual or entity to comply with the regulations. Persons with disabilities who have suffered harm from discriminatory actions have the right to petition the committee to issue an order to cease such actions. (Department of Empowerment of Persons with Disabilities, 2021)

Therefore, it can be concluded that this Royal Decree places importance on the rights and opportunities for developing the quality of life of persons with disabilities. It specifies the rights and welfare that persons with disabilities are entitled to, as well as mandates that both government and private entities must arrange or support for persons with disabilities. The decree also emphasizes the protection of the rights of persons with disabilities, including provisions against discriminatory practices and avenues for complaints and suggestions. It further supports the operations of persons with disabilities and related organizations through committees, boards, and the Fund for Promotion and Development of Quality of Life for Persons with Disabilities.

2.4.2 Policies Related to Disabled Persons

Public policy is a guideline for government decision-making on various actions or activities towards the country’s citizens. Public policy is a deliberate action by the state aimed at achieving clear objectives, involving public services, and manifesting through statements, laws, regulations, or judicial decisions. These decisions are definitive, not temporary, and involve repeated or long-term actions. The state, a group of authorized and legitimate individuals, is the policy maker. Policies related to disabled persons are public policies, meaning they are actions or activities organized by the government to manage and care for disabled persons. This responsibility directly falls on the government, which manages and looks after all citizens, including disabled individuals (Mayuree Anumanratthan, 2013). Policies related to disabled persons involve several ministries and state agencies, as follows:

2.4.2.1 Ministry of Education Policies

Disabled persons are considered human resources of society. They must be supported to develop their knowledge, abilities, and various skills, including daily living, social integration, and vocational skills, on par with other groups in the country. This support aims to enable disabled persons to be self-reliant, live happily in society, and contribute to society like everyone else. Supporting and developing disabled persons must be systematic and continuous, starting from identifying the disability, treatment, rehabilitation, education, social skills development, and vocational rehabilitation.

To sustainably develop disabled persons, they must receive equal education to that of the general population. This includes formal, non-formal, and lifelong education based on the principle of education for all, clearly stipulated in the Constitution of the Kingdom of Thailand B.E. 2560, Section 43, which states: “Every person has equal rights to receive basic education for at least 15 years from the state, with coverage and quality, without charge.” Moreover, Section 30, paragraph 3, states: "Unfair discrimination against any person based on differences in origin, race, language, sex, age, physical or health condition, personal status is not allowed." This implies that all Thai citizens have equal rights to basic education, regardless of socio-economic status or physical disabilities. The state must provide educational materials, facilities, and other educational assistance, as outlined in Section 55: "Disabled persons or those with disabilities have the right to receive public facilities and assistance from the state as provided by law."

Thailand emphasizes the importance of education for disabled persons through the following policies:

1) Service Provision: Ensure disabled persons receive education from birth or upon identification of the disability, with a focus on at least 15 years of basic education. Provide opportunities for disabled children to learn languages, science, mathematics, in general education curriculums, and vocational training to promote self-reliance.

2) Educational Opportunities: Ensure equal educational opportunities for disabled persons, similar to those for non-disabled children, and equal rights for male and female disabled individuals.

3) Educational Management: Ensure all disabled individuals desiring education can access it, expanding services in and out of the school system, emphasizing inclusion and tailoring to the type and level of disability.

4) Student Admission: Adjust regulations to facilitate the admission of all disabled children from birth or upon identifying the disability. The state should enhance early intervention services both in urban and rural areas and create a registry to certify disabilities requiring assistance, as per the Ministry of Education regulations on materials and educational facilities for disabled persons.

5) Curriculum Development: Develop curriculums, assessments, and evaluations that align with the type and level of disability, focusing on learner-centered processes, allowing disabled children to communicate and adapt their behavior to live happily in society.

6) Educational Administration: Establish a central committee to oversee and coordinate education for disabled persons, involving collaboration with departments and provinces, and mobilize support from educational institutions and

healthcare facilities. Conduct accurate surveys of the disabled population and educate parents on available educational services and how to care for disabled children from birth or upon identifying the disability.

7) Resources: Support educational institutions with resources and academic expertise to manage education for disabled persons. Encourage private sector and community involvement to ensure quality and effective education. Consider developing educational units for disabled persons into public organizations in the future following structural changes in the Ministry of Education.

8) Personnel: Improve higher education institutions' special education teacher training to ensure sufficient and quality educators. Include special education courses in teacher training curriculums and provide in-service teacher training on modern teaching techniques per the National Education Act B.E. 2542.

9) Quality Evaluation: Establish quality standards for education for disabled persons and implement systems to evaluate educators and administrators, involving relevant agencies, disabled persons' organizations, and parents in the evaluation process.

10) Private Sector Promotion: Encourage and support private sector and NGOs in providing education for disabled persons at all levels and in all forms, with state support in budget and personnel equivalent to state education (Warunee Jiranveth, 2012).

Education for disabled persons includes formal, non-formal, and informal education. Key forms of educational provision include: 1) Inclusive Education 2) Special Education Schools for Specific Disabilities 3) Family-Based Education 4) Community-Based Education 5) Hospital-Based Education 6) Special Education Centers 7) Non-Formal and Informal Education Disabled persons are entitled to 15 years of free basic education, including vocational, advanced diploma, and undergraduate education. Educational services are accessible by contacting the Special Education Center of the province, nearby schools, educational institutions, or the provincial educational service area office or designated agencies (Faculty of Medicine, Ramathibodi Hospital, 2023).

In summary, education for disabled children or individuals with impairments varies according to the type of disability. Clear classification is necessary to align teaching with the specific needs and potential of disabled persons, ensuring genuine development.

2.4.2.2 Ministry of Public Health Policies

Health and medical policies ensure all disabled persons receive equal healthcare services to the general population, with some additional rights. Disabled persons can use the Universal Health Coverage (Gold Card) as follows:

1) Gold Card Fund: Disabled persons under the Universal Health Coverage (UHC) system are those defined under the Rehabilitation of Disabled Persons Act, B.E. 2534, or those needing rehabilitation as per the criteria set by the National Health Security Office (NHSO) and registered in the UHC system. They receive a “Gold Card T.74” (for disabled persons) (Faculty of Medicine, Ramathibodi Hospital, 2023).

The National Health Security Office (NHSO) promotes equality in accessing rights through the implementation of the “National Health Security System” or “Gold Card”. This system has developed various services and benefits to ensure comprehensive and accessible care for persons with disabilities. Besides access to medical treatment and basic public health services, persons with disabilities receive benefits under the rehabilitation services rights. Their rights under the Universal Health Coverage (UHC) system include:

Primary Benefits: These include basic medical services such as health promotion, disease control, disease prevention, diagnosis, and treatment. These services can be accessed at health centers, public health service centers, all government hospitals, and private hospitals that are service units within the UHC system.

Specific Rights for Persons with Disabilities: These include exemption from the 30-baht service fee for each visit and the right to rehabilitation services both inside and outside service units. These services include physical therapy, occupational therapy, speech assessment/correction, psychotherapy, behavior therapy, hearing rehabilitation, vision rehabilitation, provision of assistive devices according to disability type, and other forms of capacity development.

Additionally, to facilitate the use of the Gold Card for persons with disabilities, they are allowed to receive medical services at any government hospital without incurring costs and without needing a referral. All Thai persons with disabilities who are not covered by other health funds, such as civil servant rights, social security, state enterprises, or other state-provided funds, are entitled to benefits under the National Health Security System.

To obtain a UHC card (Gold Card T.74), disabled persons in rural areas can register at local health stations or state hospitals, while those in Bangkok can register at any district office as per their house registration. If the disabled person cannot register themselves, a guardian can be authorized to do so. Required documents include:

(1) Copy of the national ID card or a government-issued ID with a photo. For children under 7 years, a copy of the birth certificate is required.

(2) Disability ID book or a certificate of disability assessment from a doctor (the Disability ID book can substitute for the ID card).

(3) Copy of the house registration listing the person’s name (NHSO Disability Benefits, 2021).

To use the UHC card benefits:

(1) Seek treatment at the hospital listed on the UHC card when ill. In emergencies, treatment can be sought at any state hospital and participating service providers.

(2) Inform staff when using the UHC card benefits.

(3) Present the UHC card and Disability ID book each time the benefits are used.

Additionally, disabled persons in the social security system receive public health services similar to those under the gold card system.

2) Provincial Rehabilitation Funds

Under the UHC system, there are “Provincial Rehabilitation Funds” to support essential health and living rehabilitation services. These funds are jointly funded by NHSO and the Provincial Administrative Organization (PAO). Currently, 58 provinces have established such funds, providing another layer of support to ensure comprehensive and quality care for disabled persons, improving their quality of life.

Rehabilitation aims to provide disabled persons with equal care and quality of life, under the mission to promote and develop the quality of life and education of citizens, with a commitment to help the elderly and disabled. The 58 provincial rehabilitation funds established jointly by NHSO and PAOs are listed in Table 2.7

Table 2.7 Provinces Receiving Rehabilitation Funds for Disabled Persons

Regions	**Amount of Funds**	**Province**
Region 1 - Chiang Mai	8 funds	Chiang Mai, Chiang Rai, Nan, Phayao, Lamphun, Lampang, Phrae, Mae Hong Son
Region 2 - Phitsanulok	5 funds	Phitsanulok, Sukhothai, Tak, Uttaradit, Phetchabun
Region 3 - Nakhon Sawan	5 funds	Nakhon Sawan, Chai Nat, Phichit, Uthai Thani, Kamphaeng Phet
Region 4 - Saraburi	7 funds	Saraburi, Ayutthaya, Sing Buri, Ang Thong, Nonthaburi, Pathum Thani, Nakhon Nayok
Region 5 - Ratchaburi	1 funds	Ratchaburi
Region 6 - Rayong	8 funds	Chonburi, Chanthaburi, Trat, Rayong, Samut Prakan, Sa Kaeo, Prachinburi, Chachoengsao
Region 7 - Khon Kaen	3 funds	Khon Kaen, Roi Et, Maha Sarakham
Region 8 - Udon Thani	3 funds	Bung Kan, Nong Bua Lamphu, Sakon Nakhon
Region 9 - Nakhon Ratchasima	4 funds	Nakhon Ratchasima, Chaiyaphum, Buriram, Surin
Region 10 - Ubon Ratchathani	3 funds	Ubon Ratchathani, Yasothon, Amnat Charoe
Region 11 - Surat Thani	4 funds	Surat Thani, Krabi, Phang Nga, Phuket

Regions	Amount of Funds	Province
Region 12 - Songkhla	7 funds	Songkhla, Phatthalung, Satun, Pattani, Yala, Narathiwat, Trang

Source: Adapted from National Health Security Office (2021, p. 1).

Based on the information, several provinces have participated in establishing rehabilitation funds for disabled persons. Disabled individuals have rehabilitation rights under the universal health coverage system as follows:

1) Rehabilitation Services: Disabled persons can receive rehabilitation services at state service units free of charge.

2) Assistive Devices: Disabled persons can obtain assistive devices and aids by contacting the hospital listed on their universal health coverage card. They can receive assistive devices at 11 demonstration centers, including: (1) Sirindhorn National Medical Rehabilitation Center (2) Buddhachinaraj Hospital (3) Ratchaburi Center Hospital (4) Phrae Hospital (5) Phra Pok Klao Hospital, Chanthaburi (6) Lampang Hospital (7) Sunpasitthiprasong Hospital (8) Songkhla Hospital (9) Nakhon Ratchasima Hospital (10) Nakornping Hospital, Chiang Mai (11) Maharaj Nakhon Si (12) Thammarat Hospital (National Health Security Office (NHSO), 2021).

3) Integrated Health Services Center for Disabled Persons: The NHSO aims to establish 22 centers to enhance access to health and rehabilitation services for disabled persons in the following hospitals: (1) Chiang Klang Hospital (2) Lom Sak Hospital (3) Mae Lao Hospital (4) Bang Krathum Hospital (5) Laplae Hospital (6) Takhli Hospital (7) Nang Rong Hospital (8) Pathum Ratchawongsa Hospital (9) Selaphum Hospital (10) Phu Kradueng Hospital (11) Kamalasai Hospital (12) Wanon Niwat Hospital (13) Kaeng Khoi Hospital (14) Doem Bang Nang Buat Hospital (15) Aranyaprathet Hospital (16) Thepha Hospital (17) Hua Sai Hospital (18) Krasang Hospital (19) Kuchinarai Hospital (20) Kong Krailat Hospital (21) Tha Luang Hospital (22) Chawang Hospital (National Health Security Office (NHSO), 2021).

Rehabilitation Services by Medical Processes: Previously, disabled persons received only 13 medical services, but by 2010, this was doubled to 26 services, including: 1) Diagnosis, laboratory tests, and other specialized examinations per the benefit package 2) Counseling and individual case management services 3) Medication, products, medical supplies, and special treatments for rehabilitation, such as spasticity injections and Hemoencephalography (HEG) 4) Surgery 5) Specialized nursing services, such as psychiatric nursing 6) Physical therapy 7) Occupational therapy 8) Speech therapy 9) Behavioral therapy 10) Psychotherapy 11) Music therapy 12) Exercise therapy 13) Art therapy 14) Hearing rehabilitation 15) Communication skill development 16) Developmental promotion services or early intervention services 17) Traditional and alternative medical services, such as Thai massage and acupuncture 18) Social skill development, social work, and social therapy, such as recreational groups 19) Pre-vocational or vocational rehabilitation assessment and preparation 20) Visual rehabilitation, environmental orientation, and mobility training 21) Health information services through accessible media for disabled persons 22) Training and skill development for disabled persons, caregivers, and personal assistants 23) Family and community-based rehabilitation, home visits, and proactive service activities 24) Basic learning skills training, such as life skills training and living skills training for disabled persons 25) Dental services, such as fissure sealant application 26) Services related to prosthetics, orthotics, assistive devices, or developmental support materials.

How to Access Medical Rehabilitation Services: To receive medical rehabilitation services, disabled persons must register for the Gold Card T.74 with the NHSO at a nearby healthcare facility. They must present the card to receive rehabilitation services or medical treatment free of charge at any healthcare facility (Faculty of Medicine, Ramathibodi Hospital, 2023).

2.4.2.3 Ministry of Labor Policies

Policies related to disabled persons in terms of employment and hiring are crucial. Despite physical, emotional, psychological, and social impairments that may limit work capacity, the belief in human dignity, equal rights, and equality reinforces the perspective that recognizes human potential, sharing opportunities for participation in societal activities and employment. This allows disabled individuals to gain true dignity and self-reliance. Thus, employment policies are vital for disabled persons, their families, communities, and society. These policies are formalized into laws concerning employment and hiring of disabled persons. They are outlined in the Promotion and Development of the Quality of Life of Disabled Persons Act, B.E. 2550 (2007), specifically in Section 33, which mandates employers or business owners and government agencies to hire disabled persons in suitable positions at a rate appropriate to the number of employees. The Minister of Labor issues regulations specifying the number of disabled persons to be hired by employers, business owners, and government agencies. If employers or business owners have limitations, they must adhere to the regulations.

Additionally, Section 34 stipulates that employers or business owners who do not hire the specified number of disabled persons as per Section 33 must contribute to the fund as per Section 24(5). The Minister of Labor issues regulations determining the amount to be contributed to the fund, with a penalty interest rate of 7.5% per year for late or incomplete contributions. Employers or business owners hiring disabled persons or contributing to the fund are eligible for tax exemptions proportionate to the wages paid to disabled persons or the amount contributed to the fund, as per the law.

Lastly, Section 35 provides that if a government agency or employer does not wish to hire disabled persons as per Section 33 and does not wish to contribute to the fund as per Section 34, they may instead offer concessions, such as providing sales or service spaces, subcontracting, providing training, or offering equipment, interpreters, or other assistance to disabled persons or their caregivers as per the criteria, methods, and conditions set by the committee regulations (Treemat Sarapong, 2023).

The key criteria for hiring disabled persons under the aforementioned Act are as follows:

1) Employers or business owners, both private and government, with 100 or more employees.

2) Must hire disabled persons capable of working in any position.

3) The ratio is 1 disabled person per 100 non-disabled employees. If the remaining fraction exceeds 50, one additional disabled person must be hired (e.g., 151 employees require 2 disabled persons).

4) The employee count is taken on October 1 of each year.

5) For employers or business owners with branches in the same province, the total employee count of all branches in the province is combined (Treemat Sarapong, 2023).

If employers or business owners cannot hire disabled persons due to job requirements or workplace conditions, they can:

1) Contribute annually to the Promotion and Development of the Quality of Life of Disabled Persons Fund. The contribution is calculated from the minimum wage rate under the latest labor protection law, multiplied by 365 and by the number of unfilled disabled person positions.

2) If they fail to contribute or contribute late or incomplete, they must pay 7.5% annual interest on the outstanding amount. However, hiring disabled persons or contributing to the fund qualifies for a tax exemption proportionate to the wages paid to disabled persons or the amount contributed to the fund (Treemat Sarapong, 2023).

How to Access Employment Services for Disabled Persons: Disabled individuals can apply for jobs at private businesses and government agencies that accept general or disabled applicants. They can also seek employment services at the Department of Employment’s job centers near their homes or notify organizations providing employment services for disabled persons, such as the Redemptorist Foundation for People with Disabilities in Pattaya and the Thai Disabled Development Foundation. Alternatively, they can apply at agencies announcing job openings (Faculty of Medicine, Ramathibodi Hospital, 2023).

Additionally, policies promoting the potential of disabled persons include vocational training centers like the Disabled Persons Career Promotion Center (International Year of Disabled Persons Factory) in Nonthaburi and the Ban Mookul Center for Disability and Career Development in Lopburi. The Ministry of Social Development and Human Security provides revolving funds for factories under the Department of Empowerment of Persons with Disabilities and offers loans for disabled persons to start businesses. Social security benefits for disabled persons also include special privileges, such as receiving medical treatment at any participating hospital, unlike general individuals who are limited to hospitals specified on their social security cards.

Thus, employment policies for disabled persons are clearly defined to promote employment, self-reliance, respect for human dignity, equality, and belief in the potential of disabled persons.

2.4.2.4 Ministry of Social Development and Human Security Policies

The Ministry of Social Development and Human Security is responsible for managing and caring for disabled persons, with the Department of Empowerment of Persons with Disabilities (DEP) as the primary agency. The DEP's mission includes proposing policies and creating plans for promoting and developing the quality of life for disabled persons, protecting their rights and welfare, ensuring opportunities and equality, monitoring benefit access, eliminating unfair discrimination, providing advice and assistance to disabled persons to access necessary facilities and services (Department of Empowerment of Persons with Disabilities, 2023). The Ministry's policies related to disabled persons include:

1) Loan Services for Disabled Persons or Caregivers: Disabled persons and their caregivers are entitled to loans from the Promotion and Development of the Quality of Life of Disabled Persons Fund for self-employment. Individuals can borrow up to 60,000 THB each, or groups can borrow up to 1,000,000 THB collectively for business ventures. There is no interest, but the loan must be repaid within 5 years. To access loan services, disabled persons, caregivers, or families can apply at the Provincial Social Development and Human Security Office (PSDHS), Community Welfare Protection Center in Bangkok, or designated agencies. They must submit a project proposal outlining the intended use of the loan.

2) Social Welfare Services for Disabled Persons: Disabled persons are entitled to appropriate welfare services, including personal assistants for severely disabled persons who have undergone training per Ministry standards. To access social welfare services, disabled persons, caregivers, or families can apply for personal assistants, home or care facility modifications, or support for homeless disabled persons at the Subdistrict Administrative Organization (SAO), PSDHS,

district office, Community Welfare Protection Center in Bangkok, or designated agencies.

3) Home Modification Support: Disabled persons needing home modifications for accessibility can request support from the Ministry of Social Development and Human Security or reimburse expenses if the family pays upfront.

4) Care Facilities for Homeless Disabled Persons: Disabled individuals without family or caregivers can access care facilities known as Shelters for Protection and Development of Disabled Persons, with 13 facilities nationwide.

5) Sign Language Interpreter Services: Disabled persons with hearing or communication impairments (deaf) can request sign language interpreters in five scenarios:

(1) Medical and public health services

(2)Job applications or employment-related communications

(3) Filing complaints, accusations, or acting as a witness in investigations or legal proceedings

(4) Participating in meetings, seminars, training, or being a speaker in events organized by public or private organizations

(5) Other services as determined by the Subcommittee on Promotion and Development of Sign Language Interpreters

To access sign language interpreter services, disabled persons, caregivers, or families can apply at the Association of the Deaf of Thailand, SAO, PSDHS, district office, Community Welfare Protection Center in Bangkok, or designated agencies.

6) Disability Allowance: All registered disabled persons with a disability ID card are entitled to a monthly disability allowance of 800 THB, paid in cash or bank transfer by the 10th of each month throughout their lifetime. The allowance ceases upon the disabled person’s death or voluntary renunciation. Disabled persons aged 60 or above are eligible for both the disability and elderly allowances. The steps to receive the disability allowance are:

Step 1: Register as a disabled person at the PSDHS or designated agency to receive a disability ID card (for those not previously registered).

Step 2: Register for the disability allowance at the SAO or district office in Bangkok where the disabled person is listed in the household registration (Faculty of Medicine, Ramathibodi Hospital, 2023).

2.4.2.5 Ministry of Transport Policies

A crucial factor in developing and improving the quality of life for disabled persons is enhancing the transportation system to facilitate accessibility and reduce travel barriers, ensuring equal and inclusive access to public transport services for everyone. This approach aims to bridge social gaps and empower disabled individuals to live with dignity and potential in society (Ministry of Transport, 2023). Public and private agencies must provide appropriate facilities to ensure disabled persons can access and benefit from services such as travel, public transportation, information services, and guide animal services. Expenses incurred by businesses for providing facilities for disabled persons can be tax-deductible.

The Ministry of Transport emphasizes enabling disabled persons to access and benefit from public transport services by providing equipment, facilities, and services in buildings, vehicles, and transportation services following the principles of Universal Design (UD). However, several factors have hindered the development of transportation services and facilities for disabled persons, necessitating the formulation of a “Strategic Plan for Developing Transportation Facilities for Disabled and Elderly Persons.” This strategy addresses obstacles and provides a comprehensive framework for implementation across all sectors (Ministry of Transport, 2023).

The Strategic Plan for Developing Transportation Facilities for Disabled and Elderly Persons is part of the 20-year Transportation Infrastructure Development Strategy under the National Strategy and the 5th National Plan for Quality of Life Development for Disabled Persons (2017-2021). It is also part of the 2nd National Plan for Elderly Persons (2002-2021). The strategy outlines four main areas (Ministry of Transport, 2023):

1) Policy and Legal Framework: Emphasizing the Universal Design concept and related laws in developing transportation infrastructure. This includes establishing organizations or networks to drive integrated policies.

2) Physical Infrastructure and Vehicle Adaptation: Focusing on improving or developing transportation service buildings and vehicle standards to accommodate disabled and elderly persons following laws, Universal Design principles, and Service Design principles.

3) Personnel Training: Developing curricula and training for personnel responsible for designing and providing facilities for disabled and elderly persons in transportation services. This includes activities to foster cooperation between relevant agencies and the disabled and elderly communities to raise awareness and promote positive attitudes towards disabled persons, children, and the elderly.

4) Technology and Innovation: Studying and applying technology and innovation to facilitate travel for various types of disabled persons and the elderly, such as standard websites and mobile applications.

The Ministry of Transport has applied the Universal Design principles in improving transportation service facilities in five locations: Victory Monument Bus Stop, Bangkok Bus Terminal (Borommaratchachonnani), Phra Nang Klao Pier (connecting to the MRT Purple Line), Nakhon Pathom High-Speed Rail Station, and Don Mueang Airport. These locations have been equipped with model facilities designed to accommodate disabled and elderly persons, including accessible entrances, ramps, restrooms, elevators, parking spaces, and Braille signage. Other transportation service locations, such as Hua Lamphong Railway Station and regional airports, are also being considered for future development (Ministry of Transport, 2023).

The strategic development of transportation facilities for disabled and elderly persons is crucial for adapting to changes affecting transportation system development. It aims to elevate the standards of public transportation services, ensuring disabled and elderly persons can access services conveniently and safely. Moreover, disabled persons are entitled to use public transport services, such as BTS, MRT, trains, and buses, free of charge.

2.4.2.6 Ministry of Finance Policies

The Ministry of Finance has policies and regulations for income tax deductions. Disabled persons and their caregivers with taxable income are entitled to a 60,000 THB deduction for dependent care per person. Employers hiring disabled persons can also claim tax deductions for employing disabled workers. This promotes and supports caregivers listed on the disability ID card and employers hiring disabled persons. To access income tax deduction services, applicants must notify the Revenue Department where they pay income tax or designated agencies specified by the Revenue Department. Additionally, the Ministry of Finance is responsible for managing funds for disabled persons, including disability allowances, funds for disabled persons' activities, education support, and vocational support (Revenue Department, 2021).

2.4.2.7 Bangkok Metropolitan Administration Policies

The Bangkok Metropolitan Administration (BMA) has policies for disabled persons overseen by Mr. Sanon Wangsrangboon, Deputy Governor of Bangkok. The policies are known as the “5 Good Policies” or “5 Good Areas,” aiming to improve the quality of life for disabled persons (Kritsana Srithong, 2023). These policies, developed through collaboration between the public, private, academic, and civil society sectors, include:

1) Good Health: Promoting health-enhancing activities for disabled persons through events like the “70 Days of My Miracle” and joint activities between disabled persons and their families.

2) Good Education: Emphasizing inclusive education for disabled persons. BMA aims to train all teachers in inclusive schools to become special education teachers, promoting understanding and support for disabled students. Additionally, there are initiatives like the “Inclusive Workplace” project to enhance skills for employment.

3) Good Economy: Legally requiring organizations to employ disabled persons, with a target of 1% of personnel. BMA collaborates with partners to facilitate remote work for disabled persons, such as the Live Chat Agent project, allowing disabled persons to work from home and enhancing their skills.

4) Good Transportation: Implementing Universal Design principles to improve transportation facilities for disabled persons, with a model zone at Victory Monument for comprehensive adjustments.

5) Good Management: Focusing on efficient management of health services, education, economy, and transportation for disabled persons, ensuring continuous and tangible service provision (Kritsana Srithong, 2023).

The “5 Good Policies” aim to foster understanding and change societal attitudes towards disabled persons, promoting well-being, dignity, and an inclusive society.

Additionally, BMA implements projects to support and promote disabled persons, funded by the Promotion and Development of the Quality of Life of Disabled Persons Fund for the fiscal year 2023, involving nine organizations and projects: (1) Supporting the operations and services of the Lighthouse Learning Center for the Blind. (2) Supporting the operations and services of the Thammik Asoke Foundation for the Blind, Bangkok Branch. (3) Supporting the operations and services of the Foundation for the Blind in Thailand under the Royal Patronage of H.M. the Queen. (4) Supporting the operations and services of the Foundation for Mentally Retarded of Thailand. (5) Supporting the operations and services of the Foundation for Disabled Children. (6) Supporting the operations and services of the Intellectual Disability Service Center, Bangkok. (7) Supporting the operations and services of the Autistic and Special Needs Children’s Skill Development Center. (8) Supporting the operations and services of the Thai Autism Vocational Center. (9) Supporting the operations and services of the Rom Sai Foundation for General Disability, Minburi. These projects will be submitted for approval by the Subcommittee on Promotion and Development of the Quality of Life of Disabled Persons, Bangkok, for further implementation (MGR Online, 2022).

From the above policies, it is evident that various ministries and government agencies prioritize the rights of disabled persons. If disabled persons face unfair treatment, discrimination, or significant life challenges, they should report obstacles and problems to relevant agencies, including the Provincial Social Development and Human Security Office (PSDHS), Subdistrict Administrative Organization (SAO), or provincial disabled persons’ associations and councils to ensure appropriate and equal access to services and rights.

2.5 Concepts About Family

2.5.1 Definition, Types, Key Characteristics, Qualities, Levels of Effectiveness, and Adaptation of Family Members

2.5.1.1 Definition of Family

A family is an ancient social institution that forms the fundamental foundation and has a profound influence on humans from birth to death. Understanding humans, their development, and activities requires not only focusing on individuals but also on the family, which provides a more accurate understanding and prediction of human-related aspects. Academics and institutions have defined the family as follows:

A family is a fundamental social institution comprising individuals living together, starting from at least two people (Department of Women's Affairs and Family Development, 2019). The members may be related by blood, genetics, or legally through marriage or adoption (Christie-Seely, 1984). It includes relationships such as husband, wife, children (Royal Institute Dictionary, 2011), and siblings (United Nations, 2015). Family members live together, sharing roles and responsibilities, and reside in the same household, maintaining regular interaction, concern for growth, and development of each member (Family (sociology), 2012). The family is a social unit that provides stability, structure, and security, enabling members to grow and participate in society (Collins et al., 2010).

From these definitions, a family can be summarized as a social institution or group significant to humans from birth to death. It involves individuals living together, with genetic or blood relations, such as father, mother, children, and relatives, including spouses (both same-sex and opposite-sex couples) and their children, whether legally married or not. Family members are bonded, have good relationships, share roles, and provide stability, security, and support in economic, emotional, psychological, and social aspects.

2.5.1.2 Types of Families

Families can be categorized based on structure into two main types:

1) Nuclear Family: Consists of individuals living together as husband and wife, with or without children, or a single parent living with children or siblings or relatives, usually not exceeding two generations.

2) Extended Family: Comprises individuals from three or more generations or two or more nuclear families related by genetics or blood. They share a close relationship and live together in the same house or area, including grandparents, uncles, aunts, and other relatives (Department of Women's Affairs and Family Development, 2019).

Families can also be classified based on specific needs requiring different types of support into six types:

1) Reconstituted Family: A family where one or both partners bring children from previous marriages into a new family.

2) Single-Parent Family: A family where one parent is solely responsible for raising the children due to death, divorce, or abandonment by the other parent.

3) Skipped-Generation Family: A family where grandparents live alone with their grandchildren.

4) Elderly Family: A family consisting of members aged 60 and above living together without younger generations.

5) Same-Sex Couple Family: A family where individuals of the same sex live together as partners.

6) Adolescent Family: A family where both partners are under 20 years old living together as husband and wife (Department of Women's Affairs and Family Development, 2019).

2.5.1.3 Key Characteristics of Family

Families have several key characteristics that make them unique social institutions:

1) Dynamic Nature: Families are dynamic social systems constantly undergoing change and movement, experiencing birth, growth, development, happiness, sorrow, history, and evolution.

2) Systemic Nature: Families are new systems formed by the union of individuals, comprising various subsystems like marital, parental, and sibling subsystems. Each member's position affects the entire family and social system.

3) Interaction: Family members, with their unique traits, interact with each other and their environment. Family interactions are reciprocal and governed by rules accepted universally and culturally (Satang Supaphon, 2021).

2.5.1.4 Qualities of Family

1) Families possess several important qualities distinct from other social institutions:

2) Open Socio-Cultural System: Families regularly exchange information with external systems and are constantly influenced by the community, society, schools, workplaces, and the economy.

3) Transformation: Families undergo continuous and directional changes through various life stages, such as from single to married, to having young children, teenagers, and grown-up children.

4) Homeostasis: Families maintain internal order, rules, roles, and flexibility to adapt to context, problems, and situations to ensure stability.

5) Communication: Effective communication within the family and with external systems is crucial for family well-being.

6) Family Rules: Families have specific rules that may vary between families, governing relationships and duties within the family. Boundaries: Families have clear, diffuse, or rigid boundaries that regulate interactions within the family and with external systems (Minuchin, 1974).

2.5.1.5 Family Functioning

Each family has its own characteristics and dynamics. Some families are highly functioning, where members can live well, are physically and emotionally healthy, and socially connected. Some families are moderately functioning, experiencing both happiness and sorrow, with some problems that can be resolved while others cannot. Finally, some families have low functioning, facing significant problems among members that may impact the community and external social interactions. According to Goldenberg and Goldenberg (2008), family functioning can be categorized into these three groups.

Group 1: Optimally Functional Families or also known as “Healthy Families” Characteristics include:

1) Family members express empathy, trust, and concern for each other. Each member feels valued, with their opinions respected and recognized. They also acknowledge the worth and importance of other family members. This environment avoids any member exerting dominance or authoritarianism over others, allowing everyone to freely express their opinions, whether agreeing or disagreeing, while sometimes experiencing conflicts, they can still initiate and participate in activities together.

2) Members have autonomy and respect each other’s differences, maintaining clear boundaries of individuality.

3) Family members can adapt to changing contexts, situations, and challenges effectively. They can accept and cope with various changes and developments within the family, such as illness, aging, death, or other losses.

4) Communication within the family is direct, open, warm, and hopeful, filled with humor and emotional support. They have socialization processes that enhance members’ abilities, good adaptation, and broad relationships with outsiders. They can efficiently create relationships with the external society (Satang Supaphon, 2021)

Group 2: Moderately Dysfunctional Families Moderately dysfunctional families are characterized by having a lower level of functioning compared to optimally functional families. These families often encounter problems and difficulties in performing their normal family roles. However, the problems among members in these families are not severe. In society, moderately dysfunctional families are the most commonly found type. Characteristics include:

1) Typically, these families have unclear and inconsistent roles and boundaries among parents and children. Parenting and adherence to family rules are often arbitrary, using terms like “should” and “ought to,” making it difficult for family members to consistently follow family rules correctly.

2) Parenting often involves methods of intimidation and threats rather than negotiation among family members.

3) Each family member tries to avoid responsibility for their feelings, thoughts, and actions.

4) Family members resist accepting changes that occur within the family. Competition, conflict, dissatisfaction, or disagreement are common and often occur regularly in interactions or relationships among family members. (Goldenberg & Goldenberg, 2008).

In moderately dysfunctional families, family members tend to have narrow and limited perspectives and attitudes. They may hold biased views that are sometimes inaccurate, such as perceiving women as weak, emotional, dependent on others, and needing support, while viewing men as strong, assertive, action-oriented, providers, leaders of the family, and unconcerned about emotions and relationships with others. These gender-based beliefs and misconceptions within the family can lead to problems where members struggle to adapt when facing external societal demands. When family members, particularly adolescents, need to separate from the family to pursue education or work, they may encounter two types of problems as described by Beavers (1977).

The first characteristic is the Centripetal Style, where adolescents become overly attached to their families. They may experience stress when learning to assert their independence, particularly if they encounter challenges or unfamiliar social environments. This is because the family has historically provided everything they needed, making it frightening and difficult to separate and interact independently with the outside world. Some individuals may experience significant neurotic symptoms due to this extreme stress.

The second characteristic is the Centrifugal Style, where some adolescents feel that the outside society compensates for what they did not receive within the family. This causes family members of this type to distance themselves from their family, not acknowledging family conflicts, and prioritizing friendships to alleviate their own distress.

2.5.1.6 Coping Stances

Living together as family members, whether they are related by blood, marriage, or legal guardianship, each person brings their own personality, behaviors, character traits, and values. When they come together, adaptation is necessary from each member, which may require some adjustment under normal circumstances, but becomes more pronounced when the family faces challenges. These challenges can arise from internal family issues or external influences. There are four types of adaptations that family members commonly undertake when faced with problems:

1) Blaming Style: This person tends to blame others and has a self-centered attitude. They often criticize others, have a commanding personality, and believe everything revolves around them. They set high expectations for themselves and others, like to give orders, and prioritize themselves over anything else. They tend to be loud, aggressive, and intimidating, not listening to others' opinions. Criticizing others is common, but the advantage of this style is that members are assertive, strong leaders, powerful, and creative thinkers who are easily accessible through high expectations for themselves, others, and others towards them.

2) Placating Style: This person has a gentle personality and tends to resolve problems by complying with others, neglecting themselves. They prioritize context and others' needs, wanting others to understand them. They are empathetic, often thinking of others and the surrounding context to the extent that they sometimes forget their own feelings. Eventually, they become passive, indecisive, overly reliant, pleading, begging, and self-blaming. The advantage of this style is that members are gentle, caring for others well, and easily accessible emotionally.

3) Super-Reasonable Style: This person values context, correctness, and logic, often overlooking their own and others' emotions and needs. They are intelligent, logical, and rational to the extent that they sometimes disregard emotions and feelings, both their own and others'. They are inflexible, directive, serious about life, and good problem-solvers who are easily accessible through questioning about thoughts, values, and beliefs they experience.

4) Irrelevant Style: This person is emotionally sensitive, uncertain, and indifferent towards themselves, others, and the events happening around them. They avoid facing problems and may resort to various ways to avoid confronting issues, such as changing the subject or pretending not to care. Irrelevant individuals often have an overly emotional and volatile personality, feeling lonely,

sad, and anxious, with a creative sense of humor and flexibility, and easily accessible through physical activity, sensory experiences, and physical activity (Beavers, 1977).

Each individual may adapt in all four styles, alternating between them without realizing it, but they often become accustomed to one predominant style that they display unconsciously. The “win-win adjustment” involves benefiting all parties without conflict or mutual anger, fostering mutual understanding (Congruence). This means understanding oneself, others, and the context or surrounding situation, choosing thoughts and actions that are most beneficial at that time. Opting for appropriate actions leads to positive outcomes, good feelings, and psychological well-being, utilizing problem-solving skills, reasoning, and various emotions and feelings in the present. Having wisdom in problem management, choosing the most appropriate problem-solving path, and gaining acceptance from all parties involved.

2.5.2 The Concept of Family Role Functioning

The development and well-being of a family largely depend on the daily roles performed by its members and the family as a whole. A widely used and interesting concept explaining family role functioning is the “McMaster Model of Family Functioning” (MMFF) by Epstein and Becker (1982). According to the MMFF, families are considered open systems composed of subsystems such as the spousal subsystem, sibling subsystem, and individual subsystem for each family member. It suggests that dysfunction within these subsystems can lead to problems (Epstein & Becker, 1982). The MMFF categorizes family role functioning into six dimensions, which are as follows:

2.5.2.1 Problem Solving

Problem solving refers to a family’s ability to effectively address various issues that arise, enabling the family to function and perform its duties efficiently. Each family possesses different problem-solving skills; some may handle material issues well but struggle with emotional ones. Efficient families resolve problems promptly and systematically. Issues they face are often new and manageable, not chronic and unresolved. Ineffective families approach problem-solving inconsistently, leaving matters unresolved and often escalating into chronic issues (Epstein & Becker, 1982).

2.5.2.2 Communication

Communication involves exchanging information between individuals, utilizing both verbal and nonverbal means. According to the MMFF, verbal communication holds significance as it allows for clear observation and measurement. However, nonverbal communication is equally vital as it expresses emotions through tone, facial expressions, eye contact, and gestures. Communication content is categorized into two types: material related to objects and daily life activities, and content related to emotions and feelings. Families with poor object-related communication often struggle with emotional communication as well. Effective families communicate clearly and directly with targeted individuals. When communication is inclusive and contextualized, families perform their roles more effectively.

2.5.2.3 Role

Role refers to recurring patterns of behavior that family members engage in repeatedly. Roles can be divided into two aspects:

1) Basic roles are essential for ensuring the overall well-being and normal functioning of the family. These include providing basic needs, nurturing, socializing, educating, developing skills among members, as well as providing support, and meeting sexual needs within marital relationships.

2) Other roles are specific to each family, both appropriate and inappropriate. Examples include the role of a talented son who receives a scholarship to study abroad, enhancing the family’s reputation and pride. When evaluating the feasibility of family roles, two aspects are considered:

Firstly, Role Allocation: Assigning responsibilities according to roles involves assigning responsibilities openly or privately. Efficient families clearly assign necessary responsibilities to all members. In contrast, families with issues may assign responsibilities inadequately.

Secondly, Role Accountability: Ensuring members are accountable for their roles involves monitoring whether each member fulfills their responsibilities. For instance, a father ensures his son completes assigned tasks and decides consequences if tasks are not completed. Roles and responsibilities of one member should align with those of other members. Family duties can proceed effectively when suitable assignments are made, and controls ensure complete compliance with responsibilities.

2.5.2.4 Affective Responsiveness

Affective Responsiveness refers to the ability to appropriately respond to emotions, both in terms of quality and quantity. Emotions within families can range from normal states, such as love and happiness, to crisis situations involving fear and anger. The expression of emotions varies across families, contexts, and situations. Some families may show emotions inadequately, while others may predominantly express positive emotions and struggle with expressing negative ones. For instance, a wife might avoid expressing anger towards her husband out of fear that he may become displeased, or a child might refrain from sharing feelings of sadness and missing their deceased father for fear of upsetting their mother.

2.5.2.5 Affective Involvement

Affective Involvement refers to the emotional attachment and concern that each family member has towards one another, including the expression of interest and recognition of each other’s worth. There are four levels of affective involvement:

1) Disengagement: Family members show little interest or concern towards each other, viewing family as merely cohabitation.

2) Emphatic involvement: There is genuine understanding, empathy, and sincere interest in the other party’s needs, laying the foundation for mutual understanding and caring.

3) Over-involvement: Excessive attachment that may prevent the other party from having personal space and feeling overwhelmed.

4) Enmeshment: Extremely tight emotional bonds where boundaries between individuals are unclear or almost nonexistent, blurring personal boundaries as if both parties are a single entity.

2.5.2.6 Behaviour Control

Behavior Control refers to methods used to manage or regulate the behaviors of family members. It is necessary to ensure that members conduct themselves within appropriate boundaries, avoiding personal distress and conflict. Behavior control encompasses four dimensions of necessary behaviors:

1) Behaviors that occur in response to psychological and physiological needs include eating, sleeping, defecating, sexual needs, and aggressive behaviors, among others.

2) Social behaviors include forming friendships, joining clubs, communities, and societies, among others.

3) Behaviors that may be harmful to oneself or others' physical or property include truancy, delinquency, theft, and substance use, among others.

4) Maintaining discipline within the family includes waking up early, helping with household chores, and returning home on time, among others (Epstein & Becker, 1982).

In addition to the roles of family functioning mentioned earlier, the Office of the Permanent Secretary, Ministry of Social Development and Human Security (2007) has discussed interestingly about the family's roles and responsibilities. They divided the roles of family functioning into three dimensions: social, economic, and political governance.

Dimension 1: Social Dimension The family serves as a fundamental institution, nurturing and molding human beings by providing upbringing and education that promotes holistic development in physical, emotional, mental, social, and intellectual aspects. It instills social learning for moral growth, fostering empathy, social consciousness, and communal responsibility among children through exemplary learning from parents and adult family members.

Dimension 2: Economic Dimension Family members act as both producers and consumers. As producers, they play roles as entrepreneurs, investors, or laborers, cultivating a work ethic, professional integrity, creativity, and self-discipline. As consumers, families educate and cultivate responsible consumption habits, ensuring informed choices that are beneficial, safe, budget-conscious, and health-conscious. This dual role forms the foundation for collective economic development in the future.

Dimension 3: Political Governance Dimension Families nurture political and governance skills by establishing shared roles based on rules, responsibilities, mutual respect, collaborative decision-making, reasoned negotiation, love, understanding, forgiveness, and respect. These are foundational to the way of life and coexistence in society, which constantly evolves, challenging the roles and responsibilities of parents or guardians.

Firstly, strengthening family resilience based on basic survival needs involves four factors: food, shelter, clothing, and healthcare.

Secondly, developing the intellect, emotions, and spirituality of family members to equip them with knowledge, skills, and positive attitudes toward themselves, others, and society to be applied in their professions.

Thirdly, fostering family solidarity to align with good cultural traditions for harmonious living in society (Suriyadev Tripathi, 2016).

Apart from the aforementioned family roles, the roles as per the policy and development strategy of the Department of Women’s Affairs and Family Development, 2020-2024 (Department of Women’s Affairs and Family Development, 2022) provide deeper insights into the family’s responsibilities. There are four key aspects:

Firstly, creating new quality members is about continuing and embracing the family life cycle to sustain societal well-being.

Secondly, training in childcare and nurturing family members with appropriate love and warmth according to developmental stages, including safeguarding and protecting children, grandchildren, and siblings.

Thirdly, promoting learning, lifestyles, values, principles, rules, plans, and social practices, transmitting traditions, and fostering beautiful cultures for family members to live according to good moral principles, knowing how to judge right from wrong.

Fourthly, serving as a central point to connect relationships between families and among families with communities and external society.

Therefore, when discussing the care of persons with disabilities by families, we find that within the context of the Family Role concept, it involves recurring patterns of behavior among family members, forming regular activities (Department of Women’s Affairs and Family Development, 2019). Families actively participate in planning, executing, benefiting from, and taking responsibility for various long-term caregiving activities for persons with disabilities, while maintaining a balanced interdependence among family members and the disabled individuals.

Family dynamics and effective communication within the family are crucial factors in this caregiving process. Creating quality new members to continue and sustain the family life cycle, ensuring societal sustainability.

2.5.3 Family Strength Concept

The family serves as an institution that molds and shapes individuals through training in caregiving, providing love, warmth, support, and assistance in nurturing family members. It instills morals, ethics, values, and transmits societal cultures to its members to become quality individuals and good members of society (Office of Women's Affairs and Family Institution, 2007). Therefore, a strong family promotes appropriate interactions among its members, happiness, stability, and resilience, enabling them to efficiently fulfill their roles. Positive communication fosters close bonds among members, fostering good relationships, quality time spent together, love, care, mutual respect, and support within the family. It creates a warm atmosphere where members can creatively resolve crises or stresses and actively participate in the community, society, and nation (Rachanee Sunsern et al., 2013).

2.5.3.1 Meaning of Strong Family

A strong family is characterized by individuals, starting from at least two people, living together with purpose, maintaining good relationships, closeness, understanding, concern, love, and regularly engaging in family activities together (Department of Women's Affairs and Family Institution, 2023). When a family faces challenges, its members can collaboratively address issues effectively, sustain themselves independently, and adapt to social changes and surrounding people. In changing situations, they remain stable and resilient in dealing with problems or obstacles, resolving them together constructively (Social Equality Promotion Foundation, 2023). Happy family members typically overlook each other's shortcomings, avoid blaming one another, have a desire to help and satisfy others, set life goals together, and enjoy a happy life (Charuayphon Suphap, 2009).

2.5.3.2 Standards of a Strong Family

Thailand has strengthened family standards to guide development, provide guidelines, and improve family resilience, aiming to create, nurture, and promote family members to grow into a population that is physically, emotionally, and mentally healthy. They should possess adaptive abilities, resilience to problems, and contribute positively to the country.

Strong family standards refer to requirements used as guidelines for demonstrating the resilience of families (Office of the Civil Service Commission, 2021). These standards typically include five aspects (Office of Women’s Affairs and Family Development, 2011)

1) Family Solidarity: Family solidarity refers to a family where members are dedicated to building and maintaining family unity. This solidarity fosters a harmonious atmosphere that nurtures good spirits, which forms a strong foundation for the development of ethics and morals. It serves as a shield against various harmful and dangerous influences. Creating good relationships within the family involves members expressing love, commitment, and mutual respect through communication, praise, listening, participating in activities together, caring for each other’s well-being, and sharing joys and sorrows.

2) Fulfillment of Family Roles Fulfilling family roles is crucial as families play a significant role in nurturing and caring for their members to ensure their happiness. Families have a duty to lead their members towards quality and potential in life. Family members themselves must also take responsibility for their roles and duties.

3) Self-Reliance of the Family Self-reliance within a family means that family members should be able to support themselves economically, emotionally, mentally, with information, and in learning. They should also be capable of adapting to changing situations without encountering significant life disruptions.

4) Social Capital Social capital refers to being recognized and accepted by individuals and society at large. Physical aspects of social capital for families include having stable living conditions and employment. Family members should have a social foundation in self-control, self-sufficiency, public spirit, and virtues. Educational aspects involve having a high level of education accepted by society, seeking knowledge for self-development, possessing ethical values, compassion, gentleness, and gratitude.

5) Avoidance of Risk Conditions and Adaptation in Difficult Situations Risk conditions are situations that pose danger or loss to individuals or

families. Adapting in difficult situations involves all family members making adjustments. (Social Equality Promotion Foundation, 2023). The most common causes of risk conditions in families come from risk factors and life events that cause stress within families, such as living extravagantly, excessive spending, and gambling, which can lead to family harm. Families can prevent and resolve problems to avoid issues or risks, or they may fall into challenging situations that may differ in severity among families.

2.5.3.3 Guidelines for Strengthening Families

1) Promoting Good Relationships within the Family: Building strong family relationships involves fostering love, warmth, and understanding within the family. It includes caring for each other, valuing and respecting one another, and ensuring everyone has freedom and rights within the family. In times of problems or changes, consultation and discussion among family members are essential. Each member plays a suitable role, participates in problem-solving, demonstrates sacrifice, fosters forgiveness, communicates positively, and avoids serious conflicts within the family.

2) Instilling Good Life Practices: This involves parents behaving as positive role models, training and teaching their children good practices continuously. It includes nurturing, promoting development, and fostering good relationships with family members, relatives, siblings, friends, and the community. Members should be capable of self-reliance, emotional, social, and spiritual development, having confidence in daily life, maintaining physical and mental health, adhering to spiritual beliefs, cultural traditions, and values, and embracing a positive worldview while pursuing happiness without indulging in vices like alcohol consumption, staying out late at night, gambling, engaging in bad company, or engaging in premarital sex.

3) Participating Responsibly in Society: It involves avoiding actions that create problems for oneself, the family, and society, and contributing to preventing and resolving issues. This includes not opposing or causing distress to society, participating in social support, assisting in community problem-solving, and understanding the importance of peaceful coexistence in society. (Source: Department of Women’s Affairs and Family Institution, 2007).

2.5.4 Family Management Concepts

Family management refers to the process of caring for individuals with disabilities alongside their families in their daily lives, aiming to create balance for family members facing illness, disabilities, or other challenges. Social support may be utilized to assist in managing these issues, including knowledge management related to diseases, illnesses, disabilities, and necessary care practices. Here are the five dimensions:

1) Daily Living Activities: Includes eating, sleeping, and daily routines.

2) Ability to Manage Care for Illness or Disability Requiring Special Care: Such as wound care, administering tube feeding, and providing respiratory care.

3) Readiness to Manage Health Conditions or Disabilities: Involves preparing necessary equipment, medications, and other essentials for caregiving, both physically and within the home environment. It encompasses the economic and financial aspects of caregiving, emotional and psychological aspects such as stress, mood changes, depression, and distress experienced by patients or persons with disabilities.

4) Challenges in Family Life: When illness or disability occurs to a family member, it may impact other family members. For instance, the patient or person with a disability may be the main breadwinner or pillar of the family, affecting the family’s financial status. Other family members may need to leave their jobs to care for the sick or disabled member, impacting income and causing emotional stress within the family.

5) Perspectives on the Impact of Illness: When everyone in the family, including the patient or person with disabilities, lacks proper understanding, it can lead to shame, burden, social exclusion, and reduced community engagement compared to before the illness or disability occurred. (Knafl et al., 2012).

2.5.5 Family-Centered Care Concept

In the context of Thai society, family members are close-knit, intimate, and deeply bonded. When illness, disability, old age, or life crises occur, the family becomes the most significant and supportive source physically, emotionally, and economically. Beyond familiarity and understanding the needs of family members better than any other individuals or organizations, families also demonstrate love and concern for each other. Participating in the care of family members is considered a source of pride. For elderly individuals, caregiving is seen as a way to repay gratitude and show respect.

The family serves as a central hub for caregiving, as fundamental belief dictates that families operate as systems with close interpersonal relationships, deep bonds, and a profound understanding of each member’s needs, unique structure, and real-life circumstances. Families provide emotional support, love, encouragement, value, information, news, and financial resources to their members. When changes occur within the family, whether positive or negative, they significantly impact its members. Given this perspective, families bear responsibility and play crucial roles in caring for their members, especially during health crises, illness, disability, aging, or the final stages of life (Wright & Bell, 2009). In the framework of family-centered care, the family is viewed as a vital context for individuals with disabilities. Each family is diverse, possessing unique identities, rights, and choices, and should be treated equally with other stakeholders by professionals.

Family-centered care emerged as a pivotal concept in healthcare toward the end of the 20th century. However, its implementation faced several challenges initially. Before the early 1990s, the relationships between healthcare providers—such as doctors, nurses, and health teams—and patients with disabilities or illnesses, as well as their families, were often distant. Traditional caregiving centered around medical professionals, expecting patients with disabilities or illnesses and their families to passively observe medical care without actively participating in treatment, care, or recovery. These practices were largely bureaucratic or business-oriented, viewing patient and family involvement as disruptions that could interfere with medical care and potentially harm treatment outcomes.

Subsequently, modern concepts began to evolve, allowing families to participate more actively in caregiving. This shift has proven beneficial for treatment and recovery, encompassing physical, emotional, and psychological aspects. This transformation was facilitated by the implementation of Health Maintenance Organizations (HMOs), which successfully controlled rising healthcare costs in the

1970s. As a result, relationships between patients, individuals with disabilities, families, and medical personnel improved significantly, becoming clearer and more collaborative.

In the early stages, family-centered care in healthcare emerged primarily from pediatric and geriatric medicine. Several medical institutions began adopting policies that welcomed family members to stay with patients with disabilities or illnesses full-time. As awareness grew regarding the importance of addressing social and emotional needs comprehensively, family-centered care models gained significant traction as ethical interventions. In the United States, this approach received additional support under federal law, particularly through Public Law initiatives in the late 1980s and early 1990s. These laws further endorsed the centrality of family in caregiving, enhancing quality standards, caregiver knowledge, and safety protocols. They also promoted communication between families and caregiving experts. Moreover, considering the perspectives and concerns of families and patients with disabilities or illnesses, they felt more comfortable collaborating with healthcare professionals in care planning.

Care for individuals with disabilities by healthcare professionals specialized in nursing and medical care is often constrained within the institutional walls of hospitals or healthcare facilities. Traditionally, this care focuses predominantly on nursing interventions, medication administration, physical therapy, and other medical treatments. However, recognizing the pivotal role of families in caregiving, they are integral members of the care team, contributing to physical, emotional, and psychological support. When families actively participate alongside physicians, nurses, nutritionists, social workers, and others at every stage of care, they can assist in managing and evaluating the patient’s or individual’s treatment effectively.

Family involvement allows them opportunities to consult and discuss with healthcare experts about health conditions, caregiving methods, and various health test results. They can provide insights into daily activities such as bathing, feeding, mobility assistance, exercise, and physical therapy. Additionally, families play a crucial role in offering suggestions and asking questions that reflect the patient’s or individual’s desires and concerns. This collaboration enhances the efficiency and effectiveness of care and treatment outcomes significantly.

The National Center for Family-Centered Care (NCFCC) has outlined key components of family-centered care as follows:

1) Respect and Recognition: Recognizing the enduring importance of families in the lives of their members.

2) Supporting Collaboration: Fostering collaboration between families and healthcare teams across all levels of healthcare and social welfare, including hospitals, homes, communities, and related agencies.

3) Complete and Unbiased Information Exchange: Facilitating necessary information exchange between families and healthcare teams, as well as social welfare agencies, to provide continuous support.

4) Cultural Competence and Respect: Acknowledging, accepting, honoring, and respecting cultural, ethnic, religious, economic, social, and residential differences within and among families.

5) Empowering Families: Valuing the potential of individuals with disabilities and their families, respecting individuality, and addressing family-facing challenges.

6) Understanding and Coordinating Developmental Needs: Understanding and coordinating individual and family developmental needs with healthcare service systems.

7) Stimulating and Supporting Family Networks: Encouraging and supporting families in establishing supportive networks.

8) Implementing Family-Centered Care: Implementing policies and development projects in health, illness, and recovery care that focus on family-centeredness, emotional and economic support, to meet the needs of individuals with disabilities and their families.

9) Designing Accessible Systems: Designing health service systems, social welfare services, and necessary services that are easily accessible, flexible, and responsive to the needs of individuals with disabilities and their families, which have diverse and varied cultures (Coker et al., 2010).

2.5.6 Concepts of Family Support, Promotion, and Involvement

Family support plays a crucial role as a source of strength for its members. Key aspects of family support include: 1) Informational Support: Providing various information and news to assist in decision-making and problem-solving in life management. 2) Emotional Support: Addressing the emotional challenges that individuals commonly face. Family support in this regard includes offering encouragement and reassurance, creating a warm and supportive environment, and fostering resilience in coping with various problems. 3) Labor and Resource Support: Acting as a significant labor force and providing various forms of assistance and essential resources such as financial support and necessary equipment for family members. 4) Appraisal Support: Serving as a mirror for self-reflection, assessing actions, and evaluating the impacts of these actions on family members (House, 1981).

In addition to providing support to its members, families also actively participate in various actions, especially in families with disabled members. Family and disabled people participation refers to activities or services designed to support disabled individuals and their caregivers, ensuring full participation of caregivers and families in decision-making regarding disability care (Ratchanee Sansoen et al., 2013).

2.5.7 Concepts of Family Relationships

2.5.7.1 Meaning of Family Relationships

In a family where members reside together, relationships are formed within the family unit. These relationships can be both positive and negative, involving conflicts or disagreements. Family relationships refer to the positive aspects or good relationships among family members, as per the concept of intra-family relationships (Friedman et al., 2003). It encompasses four dimensions: 1) Love and Affection: Expressions of care and concern within the family. 2) Recreational Companionship: Sharing leisure time and relaxation together within the family. 3) Respect: Mutual respect and consideration for each other. 4) Mutual Assistance: Collaborating and supporting each other as a cohesive unit. These dimensions reflect the familiarity and closeness among family members, including parents and children, extended relatives, and others residing in the household (Srithaptim Panichpan, 1984). Interaction, communication, and engaging in activities together foster various emotions and feelings among family members, such as love, commitment, understanding, respect, and mutual support (Lek Sombat, 2006). Families also participate in consultations, decision-making, and activities in a peaceful and harmonious atmosphere (Nitya Kochphakdee, 2002), contributing to a strong family system that fosters mutual support and assistance among its members in times of joy and sorrow (Lek Sombat, 2006).

Conversely, negative, or unhealthy relationships in families refer to conflicts or negative feelings among family members (Srithaptim Panichpan, 1984). These negative relationships can lead to various internal and external family problems, often stemming from inadequate family governance or leadership (Srithaptim Panichpan 1984). Values, beliefs, and practices among family members also influence their interactions and behaviors towards one another (Jiraporn et al., 2009).

Family relationships encompass various characteristics, including those between spouses, parents and children, siblings, and other family members. Positive family relationships are influenced by fundamental factors, as follows: 1) Appreciation of Family Members: Valuing each person’s worth within the family. 2) Spending Time Together and Engaging in Activities: Sharing time and participating in activities together. 3) Commitment to Family Happiness and Well-being: Having a commitment to the happiness and well-being of family members. 4) Effective Communication: Maintaining good communication with each other. 5) Faith and Religion: Upholding faith helps in maintaining patience, forgiveness, and managing family crises effectively. 6) Coping with Family Crises: Demonstrating resilience and competency in managing family crises effectively (Sirigul Isaranuraksa, 2003).

Negative family relationships can have detrimental impacts on all members, including: 1) Unhappiness and Lack of Harmony: A dysfunctional family dynamic lacking happiness, harmony, and friendliness can lead to estrangement and separation among family members. 2) Impact on Personal Image and Health: Both physical and mental health of family members can suffer due to stressful family environments, potentially leading to violence within the family and domestic abuse against women and children. 3) Deviant Behavior Among Family Members: Members may exhibit deviant behaviors such as substance abuse, gambling, or engaging in risky activities, indicating deeper underlying issues within the family structure.

These negative consequences underscore the importance of fostering positive family relationships to maintain a supportive and nurturing environment for all members.

2.5.7.2 Creating Positive Relationships and a Warm Atmosphere in the Family

The Department of Psychiatry, Faculty of Medicine Siriraj Hospital (2553) discusses principles for fostering good relationships within families, including:

1) Three main factors that promote good relationships:

(1) Appropriate praise and admiration

(2) Conflict resolution through constructive means

(3) Mutual respect and support for happiness and well-being within the family

2) Principles for Building Relationships with Family Members and Others:

(1) Cultivate good personal habits and qualities, such as punctuality, keeping promises, avoiding unnecessary borrowing of items from others, genuinely admiring others, showing empathy, and making sacrifices for others. Avoid speaking ill of others and understanding appropriate times for criticism.

(2) Enhance and cultivate your own personal image, aiming to become a dignified individual in how you sit, stand, and walk, ensuring appropriateness in all circumstances.

3) Ways to Build Relationships with Family Members and Others, Living Together with Others:

(1) Relationship between husband and wife: It is important for husbands to practice behaviors that foster a good relationship with their wives, such as being a good family leader, showing respect and admiration, nurturing affection, not belittling, and caring for them when they are ill. For wives, the starting point of a good relationship includes honesty, smiling warmly, preserving their

husband’s possessions, respecting and supporting the family according to their status, and providing encouragement when they are ill.

(2) Relationship with others: Show respect, admiration, avoid quarrels, and promptly address any conflicts that arise. Provide assistance according to one’s capabilities and status. (Sirigul Isaranuraksa, 2546).

Happiness in the family arises from building love, warmth, or good relationships within the family. This involves caring for and supporting each other, knowing and respecting loved ones, being responsible, trusting each other, and encouraging and forgiving each other when mistakes are made. Effective and continuous communication in a friendly manner, spending quality and meaningful time together, and adapting to changes in individual family members’ circumstances are also crucial factors.

2.6 Concept of Development Administration

2.6.1 Development Administration

“Development Administration” or “Administration of Development” carries significant social science implications. Gant (1979), an American scholar, initially defined and explained the concept of Development Administration based on his experience at the Tennessee Valley Authority (TVA). He emphasized that Development Administration focuses on organizational units, management systems, and processes established by governments to achieve developmental objectives. Furthermore, Development Administration serves as a governmental tool intricately linked to various developmental factors, facilitating the successful integration of social and economic objectives of the nation. Moreover, Development Administration aids in adapting governmental systems and roles of various agencies to respond effectively to development challenges. Therefore, Development Administration refers to the management of policies, plans, and projects aimed at achieving development objectives.

The development in the past emphasized economic growth, efficiency, capital accumulation, and wealth creation, following the principles of trickle-down economics. This approach posits that development should start with the elite, who have the knowledge and financial resources to invest. As they benefit from their investments, the gains are expected to “trickle down” to the lower classes, ultimately benefiting the entire society. This view suggests that the masses cannot lead development because they lack knowledge and resources. However, development paradigms have shifted to incorporate social management theories, which use a broader definition of “science” beyond just natural sciences, including systematic knowledge derived from observation, study, research, and experimentation. Social sciences encompass disciplines such as religion, education, law, political science, and public administration. These sciences involve intuition and normative theories, which are frameworks that societies or groups establish as standards for members to reference or practice, based on various reasons to achieve specific goals (Weena Pheungwiwatnikorn, 2014).

The management of social development emerged after World War II, around 1945. Amorn Raksasat (2003) asserts that this was prompted by the global devastation resulting from World War II. The war caused severe hardship worldwide, necessitating the rebuilding and development of many nations, including those newly independent from former colonial powers in the West. These newly independent countries faced poverty and lacked the capacity for self-governance and development, having previously been managed by colonial administrations. Shortly after World War II, the Cold War ensued, also known as the proxy war, further exacerbating economic crises and developmental challenges globally.

The United States emerged relatively strong from World War II due to its central positioning in both World Wars and provided leadership in the development of many countries worldwide. This era fostered modernization and westernization ideologies and provided financial assistance to numerous developing and underdeveloped nations globally. Development efforts initially prioritized economic growth or trickle-down economics. However, these approaches often failed to alleviate poverty in these countries. Conversely, they intensified the severity of issues like low human capital, despite abundant natural resources, leading to low incomes, low productivity, and poor health conditions (Amorn Raksasat, 2003).

From past developmental challenges arose the concept of ‘Social Development Management’ as a developmental approach aiming to achieve development goals. Key components include managing capacities in terms of processes, governance structures, leadership, resources, and management mechanisms. Therefore, social development management requires improving processes, mechanisms, and tools to effectively apply them in societal development. Moving beyond traditional economic-focused development, this shift aims for qualitative societal change, emphasizing sustainable development. The multifaceted developmental process includes robust economies, educated populations, freedom, reduced inequality, and prioritization of human resources, environment, and natural resources. Social development management stresses finding answers to who benefits from development, who holds power in development decision-making, and emphasizes self-reliance and self-sustaining development. Amorn Raksasat (2003) underscores the importance of equal opportunity for all groups to lead and benefit from development. Consequently, people with disabilities, traditionally viewed as dependent and burdensome to families, communities, and societies, have seen a shift with the integration of social development management concepts in disability development. Families play a crucial role as a social institution in managing and caring for people with disabilities, promoting their potential and quality of life in both material and spiritual aspects.

Goulet (1973) asserts that core values for managing disabilities within families include.

1) Livelihood: People with disabilities and their families must have basic necessities to survive, receive protection from all forms of danger, whether caused by human actions or natural disasters.

2) Self-esteem: People with disabilities and their families should have confidence in their ability to develop themselves, believe in their potential to progress, recognize their own worth, and refuse to accept a sense of fate.

3) Freedom: Through comprehensive development, people with disabilities and their families should have the ability to independently choose their social paths, enhance their capabilities, improve their lives, and pursue their desired goals (Amorn Raksasat, 2003).

In addition, the concept of “Catch” development management is another interesting approach that can be applied to managing the development for persons with disabilities, aiming to improve their quality of life. This concept highlights five key aspects:

1) Goal-oriented System: Development management must set goals for caring for and integrating persons with disabilities into families, communities, society, and the state equally and fairly, with human dignity equal to that of others.

2) Subsystems: Subsystems within the management framework include family, community, social, educational institutions, and workplaces, promoting good care and sustainable support.

3) Subsystems' Relationship with Inputs and Outputs: These subsystems interact dynamically with inputs and outputs, aiming for balanced development.

4) Short-term Change and Reversion: Changes occur periodically, influenced by various factors affecting persons with disabilities, families, communities, societal policies, laws, and economic conditions. When adjustments happen, the situation may revert to its original state.

5) Management System Functions: The management system has four functions: decision-making, communication, control, and specialized task allocation. (Suan Sunandha Rajabhat University, 2023).

Therefore, it can be concluded that caring for persons with disabilities through family involvement requires the application of social development management concepts. This approach aims to develop and manage individuals and families confidently, allowing them to autonomously develop without solely relying on state assistance. Persons with disabilities and their families can proactively develop themselves rather than passively waiting for state aid, as was often the case in the past. Families play a crucial role in caring for persons with disabilities. Development management should empower families to manage independently, with state support provided in terms of knowledge, funding, materials, equipment, and human resources. Effective disability development management should be goal-oriented, have subsystems, and be dynamic, enabling families to adequately and sustainably care for persons with disabilities, ensuring a good quality of life moving forward.

2.7 Related Research

2.7.1 Related Research

Research related to the care of persons with disabilities includes studies on the quality of life of individuals with disabilities, which identify factors contributing to a good quality of life encompassing physical, emotional, mental well-being, social relationships, and the environment. Additionally, studies have explored caregiving models within and outside institutions, innovations in disability care involving families and communities, processes for developing disabled individuals with family and community involvement, and issues faced by persons with disabilities and their families that highlight interesting approaches to disability care.

2.7.1.1 Quality of Life of Persons with Disabilities

A study on developmental management affecting the quality of life of persons with disabilities in the central region of Thapthim Siwilai et al. (2022) found that:

Physically, individuals with disabilities perceived improvements in their living environments to facilitate increased mobility and independence in daily activities without relying heavily on others. They also reported sufficient strength to carry out various daily tasks independently and expressed satisfaction with medical care. Psychologically, there was a positive correlation between emotional resilience and the quality of life of persons with disabilities, helping to mitigate negative emotions and prevent depression. This resilience enabled them to manage challenging situations and emotions effectively and maintain satisfaction with their ability to work or engage in activities they previously enjoyed.

Additionally, according to a study by Silverman et al. (2015) on elderly individuals with disabilities, emotional resilience was also found to relate to the quality of life of persons with disabilities, helping to mitigate negative emotions and prevent depression. This resilience enabled individuals with disabilities to live according to their capabilities, participate continuously in activities, and effectively manage their own situations and emotions. Furthermore, Hassanein et al. (2021) found that psychological resilience helps persons with disabilities perceive their abilities to face challenges and manage their own situations and emotions. Moreover, essential components of a good quality of life include considering the needs, expectations, and realities (life circumstances) of each individual with disabilities, which may vary (Tidarat Nongthong, & Pimpa Kachondham, 2017).

The study by Nakamyaporn Chuchat et al. (2015) on the quality of life of spinal cord injury patients following accidents in the northeastern region of Thailand found that: In rural areas, family and community relationships play a significant role in supporting individuals with disabilities. Extended family and close-knit neighborhood communities provide mutual assistance and empathy, ensuring continued support for persons with disabilities. Social relationships are crucial as they contribute to satisfaction with the assistance received from friends, awareness of one's social relationships within the community, understanding the importance of social support, and receiving assistance in various aspects of life.

Additionally, Wang et al. (2023, pp. 5-12) studied interactive programs involving persons with disabilities, caregivers (family members), and community nurses. They found that information interaction, emotional interaction, and operational interaction between persons with disabilities, caregivers, and community nurses are factors that can either promote or hinder disability care. Establishing relationships among persons with disabilities, caregivers, and community nurses to collaborate and assist each other contributes to sustained improvement in the quality of life for persons with disabilities and their families.

Furthermore, in the study by Porntip Tanthong et al. (2019) on factors influencing the development of the quality of life of persons with disabilities in the administration of Kamphaeng Saen Subdistrict, Mueang District, Nakhon Si Thammarat Province, sustainable improvement in the quality of life of persons with disabilities is facilitated by factors such as physical development, including gender, age, duration of disability, level of disability, and physical health status; psychological factors, including perception, self-image, and self-esteem; environmental factors, including safety, convenience of daily living, access to information and services; and social factors, including education level, marital status, occupation, income, and social support. These factors underscore the importance of governmental policies promoting education, access to financial services, and social acceptance.

Therefore, enhancing the quality of life for persons with disabilities involves comprehensive and appropriate support in all aspects, including fostering self-perception, self-esteem, and self-worth, as well as providing diverse and suitable welfare benefits. It also entails providing technologically advanced equipment that meets the essential needs of persons with disabilities, which are influential factors in improving their quality of life (Porntip Tanthong et al., 2019). This aligns with the findings of Thapthim Siwilai et al. (2022), who identified that the highest quality of life for persons with disabilities is primarily attributed to excellent healthcare management, followed by educational management and learning, social protection, occupational development, legislative policies, strategic operations, disability service systems, tourism and recreational support, among others. Additionally, effective management and continuous improvement in disability data systems, disaster management systems for persons with disabilities, statistical data collection on disabilities, workforce development, fund management, and rights protection promotion must be consistently implemented to align with current circumstances and efficiently carry out operations. These efforts contribute to sustainable and improved quality of life for persons with disabilities (Thapthim Siwilai et al., 2022).

2.7.1.2 Disability Care Models

From a study on developing models and management guidelines at the Disability Welfare and Development Division (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019), two models of disability care and vocational development centers have been identified:

1) Institutionalization Model: There are four institutions: (1) Fuenfaifa Shelter and Disability Development Center, Nonthaburi Province (2) Nonthapum Shelter and Disability Development Center, Nonthaburi Province (3) Phrapradaeng Shelter and Disability Development Center, Samut Prakan Province (4) Karunyawet Shelter and Disability Development Center, Chonburi Province

According to Tharathip Ananchai’s study (2018) on evaluating the Warm Love Children project through the CIPP MODEL, families who enroll disabled people in institutionalized care face difficulties due to poverty, lack of time, and knowledge. Disabled individuals require services for physical rehabilitation and psychological recovery (Yanisa Muanghamani, 2015).

2) Deinstitutionalization Models for Disability Care involve transitioning from institutional care to community-based services. This shift includes day care centers and a revolving door model. There are two main models: (1) Family-based Management and Development: This model emphasizes family-centered care within and outside institutions, which is not a one-size-fits-all approach. Therefore, institutional management and development models should be developed. (2) Community-based Management and Development: This model emphasizes community-based care within and outside institutions.

The family and community-based service model is considered the most developed approach because it helps shift care responsibilities from institutional settings to reducing institutionalization. It enhances caregiving roles through family and community foundations, supporting and promoting inclusion within families and communities. This approach enables people with disabilities to live the lives they choose, ensuring equal rights for all individuals with disabilities to live within families and communities with options comparable to others. Services for families and communities are provided with equal accessibility to meet the needs of people with disabilities on par with the general population. (Tunyaluk Roongsangjun, 2020).

2.7.1.3 Innovations in Disability Care Using Family and Community

A study on the development of disability care systems using families and communities as a base, conducted by Ratchanee Sansoen et al. (2013), identified two innovations in disability care:

The first innovation comprises four core concepts: 1) Seamless Continuum of Care: Providing continuous care without interruption. 2) Family Strength: Strengthening the role and capacity of families. 3) Community Capability: Enhancing community capacity. 4) Shared Learning for Goal Achievement: Collaborative learning towards achieving goals. These are supported by eight principles of care: 1) Family Role: Recognizing and enhancing the role of families. 2) Network Role: Involving networks and support systems. 3) Access to Services: Ensuring accessible service delivery. 4) Seamless Coordination: Coordinating care seamlessly. 5) Preparedness of Services: Providing appropriate services. 6) Family and Individual Participation: Involving families and individuals in decision-making.

7) Respect for the Dignity of Persons with Disabilities: Upholding dignity and respect. 8) Accountability: Taking responsibility for actions.

Innovation 2. “WE CAN DO by TIM,” is a successful process in developing cooperative partnerships, comprising 7 steps and 3 key attributes: 1) W - Willing: Creating determination, dedication, and cooperation in caring for persons with disabilities. 2) E - Exploration: Collaboratively exploring, identifying, and reflecting on needs. 3) C - Cognition: Pooling collective thinking power for development. 4) A - Acting: Collaboratively implementing desired care systems. 5) N - Notice: Participating in evaluation and providing feedback. 6) D - Decoration: Seeking and developing improvements. 7) O - Outstanding: Achieving excellence, continuity, and sustainability through empowerment. The 3 attributes (TIM) are: 1) T - Team Approach: Volunteer partnerships must work as a team in caring for persons with disabilities. 2) I - Inspiration: Volunteer partnerships must be inspired in their care efforts. 3) M - Mankind: Volunteer partnerships must have shared knowledge for the benefit of humanity. (Ratchanee Sansoen et al., 2013).

Innovation 1 and Innovation 2 focus on ideas and processes to develop care for persons with disabilities through family and community involvement, resulting in empowerment for persons with disabilities, their families, and caregiving communities (Ratchanee et al., 2013). Additionally, the study by Suchitra Eabab (2017) on nursing innovations to enhance the quality of care for children with bronchiolitis treated with aerosol inhalation therapy involving families found that family-centered care consists of four steps (EFFE): 1) Empowerment in Information Sharing and Care Planning: Empowering caregivers through information exchange and planning, discussing general matters, exchanging information on care issues, and other beneficial caregiving information. 2) Family-Professional Collaboration and Participation: Collaborative care by nursing teams with mothers or families, considering strengths, needs, and differences of each family for planned mutual care. 3) Family as a Leader and Self-Monitoring: Empowering families to lead and self-manage care. 4) Evaluation of Care: Care assessment. Therefore, innovations in family and community-based care for persons with disabilities promote the development of physical, emotional, mental, spiritual, and social quality of life for persons with disabilities and their caregiving families, enhancing their resilience and ability to provide better care in the future (Ratchanee Sansoen et al., 2013).

2.7.1.4 Development Process of Persons with Disabilities through Family and Community Participation

In caring for persons with disabilities, development must occur concurrently. The development process should be a clearly continuous process, as found in the study by Supawadee Wisuwan et al. (2017) on promoting the quality of life of persons with disabilities through family and community participation: A case study in Hin Dad Subdistrict, Huai Thalaeng District, Nakhon Ratchasima Province. The study identified the development process of persons with disabilities through the participation of families and communities as follows:

1) Social factors or costs: Leaders of organizations have a vision to alleviate poverty. People with disabilities should have a good quality of life, understanding that they need comprehensive rehabilitation in medical, educational, social, and occupational aspects. Access to community resources should ensure equal rights. Early childhood development centers and local schools provide opportunities for disabled individuals to access education.

2) Planning through collaborative thinking: Diverse ideas are gathered to analyze needs, including medical rehabilitation, surgery, physical therapy, inclusive education, and vocational training. Community-based occupations may require borrowing to work at home, analyzing market needs, group integration, and management.

3) Development process: It’s a process to achieve goals through individual development plans, collaborative learning processes, and shared trial goals with disabilities as the center. According to a study on the general rehabilitation service framework for intellectual disabilities, autism, and learning disabilities by Kwanpracha Chiangchaisakulthai et al. (2022), training in life skills and social skills reduced family caregiving burdens.

4) Outcome evaluation process: It is to evaluate individual recovery goals according to the plan. Successful points for each sub-goal are found and areas for improvement are identified. It’s an evaluation for continuous learning to set future goals.

Promotion and Development Process of Quality of Life for Persons with Disabilities through Family and Community Participation To promote and develop the quality of life for persons with disabilities, it is essential for families and communities to participate in analyzing situations, planning, designing, and evaluating rehabilitation and development activities. According to the study on the framework for general rehabilitation services for individuals with intellectual disabilities, autism, and learning disabilities by Supawadee Wisuwan et al. (2020), it was found that involving family peer counseling services helps parents and families accept disabilities, reduce barriers, understand disability potential, and provide temporary respite care. This service allows disabled individuals to stay with their peers and caregivers who are familiar with them around the clock. Caregivers or caregivers can also have time to run errands or rest temporarily, helping to alleviate stress, pressure, and negative feelings from long-term caregiving. Additionally, if there are long-term disability care services using the community as a base (life stop service), where the community is a society where disabled people live and if the community is strong and emphasizes helping, caring, and supporting the disabled and caregivers, it will be another social force to support and protect the disabled so that they can live happily and have a good quality of life. Furthermore, having family support services (family support) found that problems arose in managing family life, such as economic problems and time allocation problems in caring for the disabled, to help families and disabled people live more easily. Therefore, disabled people can access essential rehabilitation services more easily. These family support services may be provided in the form of family income support, access to low-cost or free internet services for families with disabilities, and help disabled people and families access useful information in skill training for disabled people themselves.

2.7.1.5 Problems and Limitations of Persons with Disabilities and Their Families

In the development and care of persons with disabilities, it is found that there are health-related problems or limitations affecting both the disabled individuals themselves and their families or caregivers. These include:

1) Problems with Participation of Persons with Disabilities Persons with disabilities face challenges in participating in various activities. Based

on the study "Research on Problems and Access Patterns to Health Services for Persons with Disabilities: Study Area of Municipalities in Mueang Sri Kai and Tha Tad Subdistricts, Ubon Ratchathani Province" by Kittiwat Chatrisriphop, & Faculty of Law, Ubon Ratchathani University. (2015), it was found that:

Persons with disabilities encounter difficulties in transportation, lack of accessibility facilities, and communication barriers with others. Economic issues such as lack of transportation fare and food expenses further exacerbate their challenges. The study on "Development and Promotion of Quality of Life for Persons with Disabilities for National Security" by Phinyo Prakobphon (2016) revealed that most persons with disabilities come from economically disadvantaged backgrounds, which limits their opportunities for development and continuous rehabilitation. This situation leads to additional problems such as limited access to educational opportunities, unemployment, and inadequate environmental and public services support for their livelihoods. Furthermore, many persons with disabilities also face constraints in accessing information, participating in decision-making processes, and being selected for employment opportunities.

2) Issues in Caregivers' Perception of Caring for Persons with Disabilities Caregivers of persons with disabilities face challenges in their understanding and ability to care, as revealed in the study "Learning Program Impact on Knowledge and Abilities in Caring for Stroke Patients" by Jinda Rattanakul et al. (2013). The study highlighted the following caregiving aspects: Nutritional Care: Caregivers expressed a need for assistance and support in nutrition-related care. Daily Living Activities: There is a requirement for knowledge and skills in assisting with daily routines. Mobility: Caregivers need support in understanding and assisting with mobility issues. Additionally, caregivers encounter several problems in caring for others, including: (1) Lack of knowledge about specific conditions. (2) Inability to perform daily caregiving tasks effectively. (3) Family members rotating in caregiving roles. (4) Lack of supportive equipment. (5) Inconsistent information from healthcare providers, leading to misunderstandings among caregivers.

3) Lack of a Good Social Support Network From studies such as "Religious Beliefs, Challenges, Social Support, and Rehabilitation of Family Members with Chronic Illness" by Kanyawee Promphan et al. (2013), and "Quality of

Life of Persons with Disabilities in Subdistrict Administrative Organizations in Thasala District, Nakhon Si Thammarat Province: Factors and Development Guidelines" by Thanirat Phongphaew (2014), it has been found that a lack of a good social support network poses significant challenges. A strong social support network involves communities, societies, government organizations, and private sectors coming together to provide assistance and support. This includes organizing meetings and discussions, facilitating joint activities between persons with disabilities and the community, as well as planning and improving living conditions to better accommodate the needs and daily lives of persons with disabilities. Moreover, creating suitable vocational opportunities that align with the abilities and requirements of persons with disabilities serves as a driving force for them and their families to achieve a better quality of life.

4) Lack of Knowledge and Access to Rights of Persons with Disabilities From studies such as "Guidelines for Developing Service Operations, Promoting and Improving the Quality of Life of Persons with Disabilities under the Disabilities Promotion and Development Act" by Phakchon Matcha (2013), it has been found that persons with disabilities and their families who care for them have the highest level of accurate knowledge and understanding regarding rights related to social welfare and livelihood support, due to extensive publicity through television and various media. However, they have the lowest level of accurate knowledge and understanding regarding rights related to education and other essential welfare aspects necessary for their care, daily living, vocational activities, or employment. Consequently, they often do not access these rights, particularly those available from non-profit organizations and non-governmental organizations (NGOs), either because they lack awareness or because they are not the primary targets of these organizations.

Therefore, providing social support to persons with disabilities and their caregivers in various aspects such as encouragement, promoting caregiving, offering guidance, and providing information for daily living can significantly enhance their happiness and satisfaction with life. Close sources of social support for persons with disabilities include spouses, children, grandchildren, friends, and relatives (Kanyawee Promphan et al., 2013). Addressing the needs and health conditions of persons with disabilities appropriately helps them undergo transformations in physical, mental, and social aspects, thereby improving their overall quality of life.

CHAPTER 3

RESEARCH METHODOLOGY

The study on the care of individuals with severe disabilities by families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, aims to examine the caregiving approaches and methods used by families for individuals with severe disabilities in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, and to develop a caregiving model for such individuals. This research is conducted using qualitative methods and includes the following sections:

3.1 Research Paradigm
3.2 Research Concepts
3.3 Research Methodology
3.4 Research Area
3.5 Target Group and Key Informants
3.6 Data Collection Methods
3.7 Data Analysis Methods

3.1 Research Paradigm

This study investigates events, characteristics, and social phenomena that are diverse, complex, dynamic, and vary according to the context of each family. The researcher aims to seek knowledge and truth to describe and explain these phenomena using the Critical Paradigm (Guba & Lincoln, 2005). This approach seeks diverse ontological knowledge with the goal of critiquing existing conditions, leading to some form of change focused on emancipating humans from domination (Pichai Rattanadilok Na Phuket, 2016). The ontological perspective of this study includes critical realism, historical realism, and relativism. The epistemological approach combines perspectivism and relativism, while the methodology involves dialectic and dialogue (Pichai Rattanadilok Na Phuket, 2016). The aim is to seek knowledge for the emancipation of humans from domination and to expand social acceptance for the disadvantaged. The study also aims to deconstruct and reconstruct to facilitate paradigm shifts in society (Suthida Chaengprajak, 2020). The approach to knowledge-seeking follows the philosophy of Pragmatism, focusing on practical outcomes. The practical application of ideas, their effectiveness, and real-world results are emphasized (Chaiwat Attaput, 1975). This paradigm values practical results over principles or theories, not denying the importance of principles but emphasizing the feasibility of practical application over rigid adherence to any single theory (Prathum Angkurarohit, 2008). The focus is on using truth or practical realities as tools to achieve the goals.

This research employs qualitative methods, utilizing in-depth interviews to investigate the conditions, approaches, and models of caregiving for individuals with severe disabilities by their families. The research comprises three phases: Phase 1: Examine the problems, forms, and methods of caregiving for individuals with severe disabilities by their families (Look). Phase 2: Consider and evaluate solutions, forms, and appropriate methods for caregiving (Think) (Sompong Pamulira, 2018). Phase 3: Analyze, synthesize, and derive lessons from the study results to develop a caregiving model for individuals with severe disabilities within families, as illustrated in Figure 3.1.

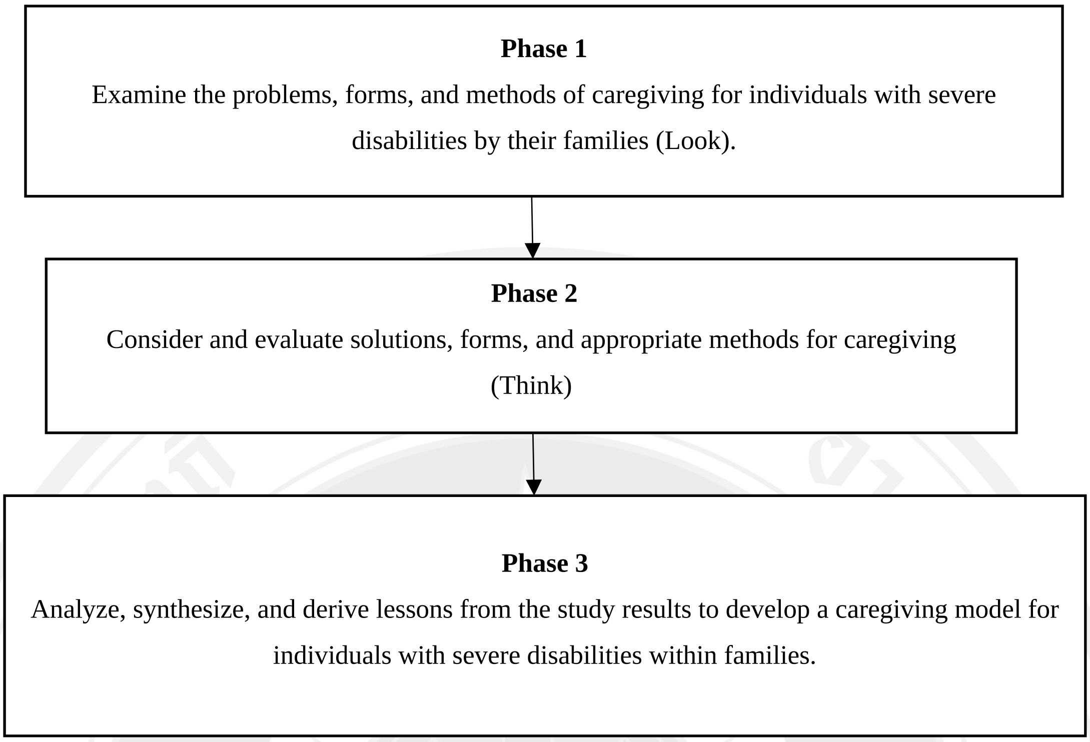
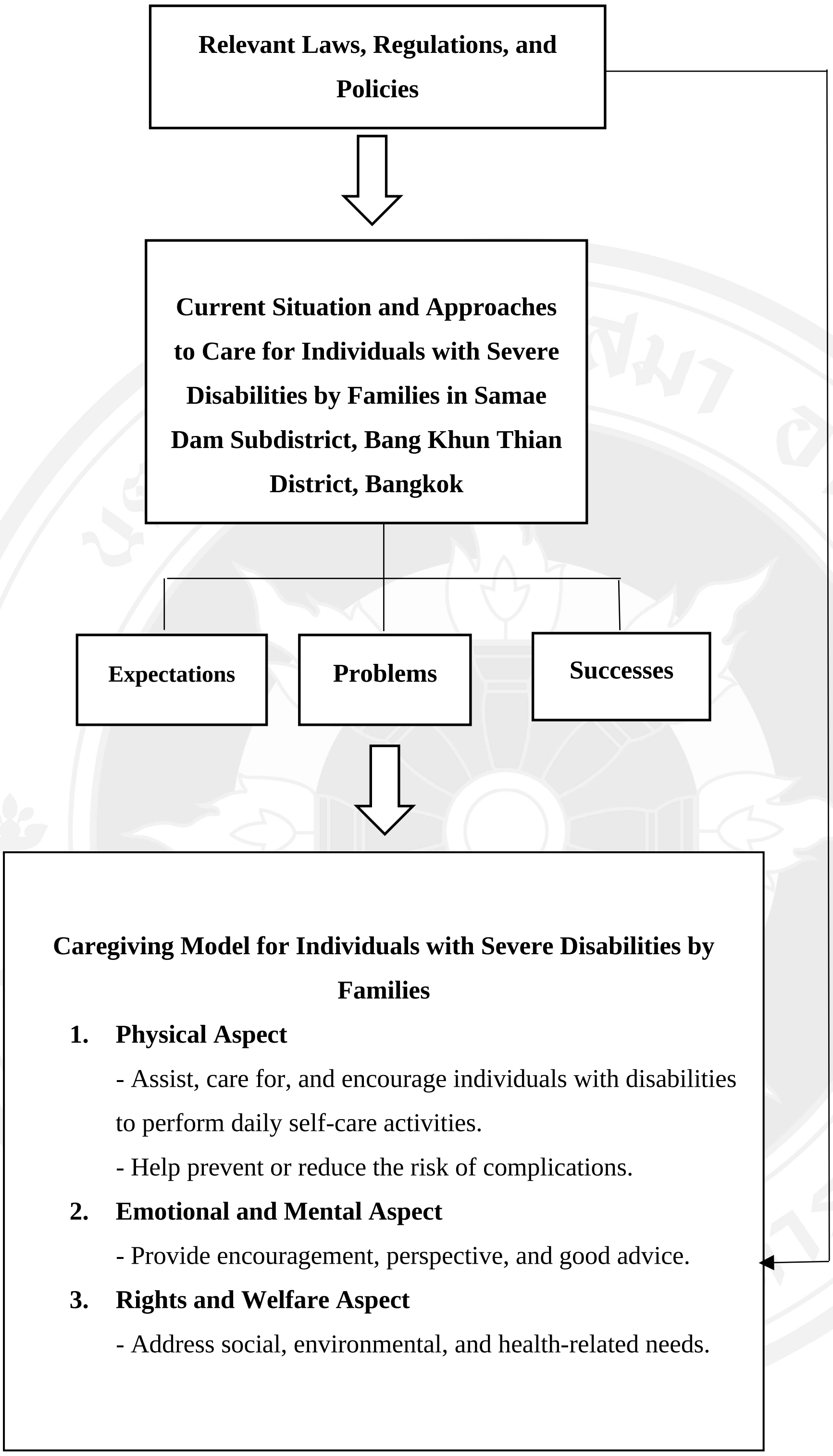


Figure 3.1 Process of Stakeholder Participation in Research
Source: Adapted from Sompong Pamulira (2018, p. 5).

3.2 Research Concept

From the literature review on the care of individuals with severe disabilities by families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, it was found that the research concept begins with the analysis of content, concepts, theories, policies, and related research on the care of people with disabilities in Thailand and abroad. This includes studying individuals with disabilities, families who care for those with severe disabilities, and academics or experts in the field of disability through in-depth interviews. The gathered information is then analyzed, synthesized, and used to derive lessons to develop a caregiving model for individuals with severe disabilities by their families.

Thus, the research concept has been developed from the literature review, studying the current care practices for individuals with severe disabilities by their families. The caregiving approaches are analyzed in three areas: 1) Physical, 2) Emotional and Mental, and 3) Rights and Welfare. Additionally, the study examines relevant laws, regulations, and policies within the country, such as the Persons with Disabilities' Quality of Life Promotion Act, B.E. 2550 (2007), and policies from various ministries. International frameworks such as the Universal Declaration of Human Rights and the United Nations Convention on the Rights of Persons with Disabilities are also reviewed. Moreover, the research explores the expectations for assistance and support, challenges, and successes in family caregiving for individuals with disabilities. Family caregiving is an interesting model because the family is a social institution bound by blood relations, and individuals with disabilities have been living with their families since birth. This results in greater physical and emotional well-being for the disabled individuals compared to living with others. The study aims to present the current caregiving practices and approaches, leading to the creation of a caregiving model for individuals with severe disabilities by their families. This is achieved through in-depth interviews with individuals with severe disabilities, family members who provide care, and academics and experts from government, private, and civil society sectors. The resulting model will be a valuable resource for those caring for individuals with severe disabilities to ensure appropriate and effective care, as illustrated in Figure 3.2.



1. **Physical Aspect**
   - Assist, care for, and encourage individuals with disabilities to perform daily self-care activities.
   - Help prevent or reduce the risk of complications.
2. **Emotional and Mental Aspect**
   - Provide encouragement, perspective, and good advice.
3. **Rights and Welfare Aspect**
   - Address social, environmental, and health-related needs.

Figure 3.2 Conceptual Framework

3.3 Research Methodology

3.3.1 Research Design

This study employs a qualitative research approach, collecting both primary and secondary data. Primary data is gathered through in-depth interviews, while secondary data is obtained from documentary studies. These studies include examining principles, concepts, theories, and related research from academic documents, journals, books, research reports, and information retrieved via the internet. Relevant policies, regulations, published documents, as well as data and statistics, are also reviewed to ensure comprehensive and well-rounded information for analysis. The research design is structured into four phases as follows:

Phase 1: November 2023 to February 2024 - Literature review, research design, and application for human research ethics approval.

Phase 2: March to May 2024 - Data collection and preliminary data analysis.

Phase 3: June to July 2024 - Data analysis, conclusion, and discussion of the study results.

Phase 4: August to September 2024 - Thesis revision based on committee recommendations, final review for completeness, and preparation of the thesis document.

3.3.2 Research Methods

Phase 1: Study the care and develop guidelines for the care of individuals with severe disabilities by their families. This is done through in-depth interviews with individuals with severe disabilities, families who care for those with severe disabilities, and academics or experts in the field of disability.

Phase 2: Analyze, synthesize, and derive lessons from the results obtained in Phase 1 to develop a caregiving model for individuals with severe disabilities by their families.

3.3.3 Research Instruments

1) Semi-structured Interview Guide: Used for conducting in-depth interviews.

2) Voice Recorder: Used to record audio during interviews for detailed data collection.

3) Still Camera: Used to capture images of important activities.

4) Note-taking Instruments: Notebook and pen used for recording information from in-depth interviews, including speech, atmosphere, and behaviors of the informants, to facilitate transcription.

3.3.4 Research Ethics

Data collection from the sample group must be approved by the Human Research Ethics Committee before collecting data from the sample group (Research Project Code: ECNIDA 2024/0048). The researcher will have the informants or sample group sign a consent form, explaining and clarifying the research project, its benefits, risks, drawbacks, criteria for participation, and informing them that they can withdraw from the study at any time.

For confidentiality, if data is recorded in electronic files or on flash drives, it will be encrypted and stored in a locked drawer, accessible only to the researcher and the research team. Paper records will be kept in a locked drawer. Participants will be informed that the researcher will keep all documents and files for one year after the publication of the research. After one year, the researcher will destroy the paper documents using a shredder and delete the electronic files from all computer databases. For image, audio, and video files (if participants consent to such recordings), the researcher will delete these files immediately after data analysis is complete.

3.4 Research Area

The research area for this study includes individuals with severe disabilities and their families who care for them, residing in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok. It also includes academics or experts in the field of disability. The area was specifically chosen for having the highest number of registered individuals with disabilities in Bangkok.

3.5 Target Groups and Key Informants

3.5.1 Target Groups

3.5.1.1 Individuals with severe disabilities being cared for by their families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok.

3.5.1.2 Families caring for individuals with severe disabilities in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok.

3.5.1.3 Academics or experts specializing in disabilities.

3.5.2 Sample Groups

The study employs purposive sampling methodology, utilizing in-depth interviews with the following primary informants:

1) Individuals with severe disabilities who are under continuous care by their families for at least 3 years, residing in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, aged 18 years and above. There are 6 participants in this group.

2) Families caring for individuals with severe disabilities continuously for at least 3 years, residing in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, with a minimum age of 18 years. There are 6 participants in this group.

3) Academics or experts in the field of disabilities, totaling 6 participants with the following qualifications:

(1) 2 academics with expertise demonstrated through teaching, research, or academic publications related to disabilities for at least 3 years.

(2) 2 experts from governmental agencies with experience in policy-making, planning, or legal frameworks related to disabilities for at least 3 years.

(3) 2 experts from non-governmental or social sector organizations engaged in service provision or advocacy related to disabilities for at least 3 years.

3.6 Data Collection Methods

1) Consultation and Meeting: Consult and hold meetings with the thesis advisor for guidance on conducting the thesis, in the Faculty of Social Development and Administrative Strategy, National Institute of Development Administration.

2) Framework and Planning: Develop a framework and plan the implementation for improving the care of individuals with severe disabilities by families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok.

3) Research and Data Collection: Study and collect data on the situation of the development of care for individuals with severe disabilities by families in Thailand and abroad.

4) Ethics Approval: Apply for human research ethics approval from the Human Research Ethics Committee of the National Institute of Development Administration (Project Code: ECNIDA 2024/0048).

5) Field Data Collection: After receiving ethics approval, conduct field data collection and analyze the situation of the development of care for individuals with severe disabilities by families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok, and compare with other countries.

6) Community Coordination: The researcher will coordinate with the community to schedule field visits. If certain areas are not convenient, the researcher will adjust the schedule accordingly.

7) In-depth Interviews: Conduct in-depth interviews with stakeholders involved in the care of individuals with severe disabilities by families in Samae Dam Subdistrict, Bang Khun Thian District, Bangkok. This includes: In-depth interviews with 6 individuals with severe disabilities In-depth interviews with 6 family members of individuals with severe disabilities and In-depth interviews with 6 academics or experts on disabilities.

8) Non-participation Observation and Informal Interviews: Conduct non-participation or direct observation, combined with informal interviews when the situation allows. The data obtained from these observations will be analyzed together with the interview data.

3.7 Data Analysis Methods

The data analysis is divided into two parts: 1) Concurrent Analysis with Data Collection: This involves understanding the content of the data received and verifying the accuracy of the data from various sources. If clarity is not achieved, additional data collection will be conducted to ensure completeness. 2) Post-collection Data Analysis: Once all data collection is complete, another round of analysis will be conducted. There will be additional content analysis, typological analysis, followed by interpretation and analytic induction. The data analysis guidelines are as follows:

3.7.1 Data Organizing

To organize the collected data for convenient analysis, the process begins by transcribing in-depth interview recordings and notes from observations into documents, which are then stored on a computer. The organized data will be read and reviewed to ensure understanding. Summaries of the data will be created for easy retrieval. This organizing process will be performed shortly after each data collection session.

3.7.2 Data Display

After organizing the data, it will be categorized according to the topics defined in the research framework. The data will be displayed by topic or issue. If new topics or issues emerge, additional categories will be created. The data will then be connected and relationships between the topics or issues will be explored. Efforts will be made to group related topics for analysis, organizing text into categories based on their meaning and content connections.

3.7.3 Data Verification

The researcher will verify the reliability of the conclusions in three ways: 1) Data Verification: Cross-checking the same set of data from multiple sources to ensure its accuracy. If the data is consistent and corroborative, it is considered accurate and clear. If discrepancies are found, further verification or additional data collection will be conducted until clarity or data saturation is achieved. 2)

Triangulation: Using multiple data collection methods, including observation, natural conversation, in-depth interviews, and document review, to compare and cross-verify the consistency of the data obtained through different methods. 3) Consultation: Engaging with the sample group, the researcher, and disability experts to reflect and confirm the findings and conclusions of the study.

3.7.4 Conclusion, Interpretation, and Verification

After displaying the data, all collected information will be synthesized and explained by each topic. Connections between the topics and their context will be identified. This process will involve summarizing and interpreting the data using relevant theoretical concepts from the literature review in Chapter 2 as a framework for analysis and comparison. The findings will be connected to various contexts to explain the discoveries. Conclusions and discussions of the research results will then be formulated. Finally, the results will be presented in a descriptive report.

CHAPTER 4

RESULTS

The presentation of research findings on the care of severely disabled individuals by families in Sam Dum Subdistrict, Bang Khun Thian District, Bangkok, has three main objectives: 1) to study the current state of care for severely disabled individuals by families in Sam Dum Subdistrict, Bang Khun Thian District, Bangkok, 2) to explore the approaches to care for severely disabled individuals by families in the same area, and 3) to develop a model for the care of severely disabled individuals by families. The findings were obtained through the analysis and synthesis of data collected from document research and field data collection, primarily using qualitative research methods, including in-depth interviews with key informants and non-participant observation. The research findings are divided into five sections as follows:

4.1 Context of the Area

4.2 General Information of Key Informants

4.3 Current State of Care for Severely Disabled Individuals by Families in Sam Dum Subdistrict, Bang Khun Thian District, Bangkok

4.4 Approaches to Care for Severely Disabled Individuals by Families in Sam Dum Subdistrict, Bang Khun Thian District, Bangkok

4.5 Development of a Model for the Care of Severely Disabled Individuals by Families

4.1 Context of the Area

4.1.1 Population in Sam Dum Subdistrict

Sam Dum Subdistrict in Bang Khun Thian District, Bangkok, has a population of 122,925 people with a population density of 3,416.96 people per square kilometer

(Department of Administrative Registration, 2022). It is the most populous subdistrict in Bang Khun Thian District.

4.1.2 Area Characteristics

Bang Khun Thian is one of the 50 districts of Bangkok. The northeastern part of the district is an area for residential, commercial, and industrial purposes, while most of the district is agricultural land with ecological tourism attractions. This is because it is the only district in Bangkok with a coastline along the Gulf of Thailand (approximately 5 kilometers long) and still retains some mangrove forests. Bang Khun Thian is located at the southernmost part of Bangkok and is bordered by the following administrative areas: To the north, it borders Bang Bon and Chom Thong districts, separated by the Wongwian Yai-Maha Chai railway line, Wat Sing Canal, Sanam Chai Canal, Wat Kok Canal, Bua Canal (Tae Pleng Canal), and Ta Suk Canal. To the east, it borders Thung Khru district and Phra Samut Chedi district in Samut Prakan Province, with boundary canals being Bang Mod Canal, Rangsit Canal, Rangsit Duan (Suan Canal), Rangsit Kanok Canal, Na Canal, and Khun

Ratchapini Chai Canal (Kong Canal). To the south, it borders the Gulf of Thailand, and to the west, it borders Phanthai Norasingh sub-district and Bang Nam Chuet sub-district in Mueang Samut Sakhon district, Samut Sakhon Province. The boundary with Samut Sakhon Province is defined by Bang Sao Thong Canal, Soong Canal, Phaniang Canal, Ta Maen Canal, and Sam Dam Sub Canal. Originally, Bang Khun Thian was inhabited by Mon people who migrated from Samut Songkhram Province during the late reign of King Rama IV. It is an old district, believed to have been established in 1867, initially under Thonburi Province. Later, when the northeastern area of the district (along the edges of Dan Canal, Dao Kanong Canal, and Bang Khun Thian Canal) developed and new communities formed, the government established Thonburi City Municipality in 1936, including Bang Kho sub-district. In 1965, the Bang Khun Thian Health District was set up in parts of Bang Khun Thian sub-district and Bang Mod sub-district. Subsequently, the Thonburi and Phra Nakhon Provinces were merged into Nakhon Luang Bangkok Thonburi and later renamed Bangkok. Over time, the area was divided into districts and sub-districts instead of counties and sub-districts, leading to the transformation of Bang Khun

Thian into a district with seven sub-districts: Bang Khun Thian, Bang Kho, Chom Thong, Bang Mod, Thakham, Bang Bon, and Sam Dam. As the population in the district became denser, Bangkok established a branch office of the Bang Khun Thian District Office to manage four sub-districts, which were later separated into Chom Thong District in 1989 and, in 1997, the Ministry of Interior announced the separation of Bang Bon sub-district to form Bang Bon District (Department of Registration Administration, 2022).

Sam Dam is an administrative area within Bang Khun Thian District, Bangkok. The general condition of the area is residential. Sam Dam Sub-district is bordered by the following neighboring administrative areas: To the north, it borders Bang Bon Sai Sub-district, Bang Bon Canal Sub-district (Bang Bon District), Bang Khun Thian Sub-district, Chom Thong Sub-district (Chom Thong District), and Thakham Sub-district (Bang Khun Thian District), with the Wongwian Yai-Maha Chai railway line, Wat Sing Canal, and Sanam Chai Canal serving as boundary lines. To the east, it borders Thakham Sub-district (Bang Khun Thian District) with Sanam Chai Canal as the boundary line. To the south, it borders Thakham Sub-district (Bang Khun Thian District) with Sanam Chai Canal, Phaya Chaiyos Somboon Canal, and Ta Nern Canal as the boundary lines. To the west, it borders Phanthai Norasingh and Bang Nam Chuet Sub-districts (Mueang Samut Sakhon District, Samut Sakhon Province) with Sam Dam Lower Canal, Sam Dam Upper Canal, and the administrative boundary between Bangkok and Samut Sakhon Province as the boundary lines (Department of Registration Administration, 2022).

4.1.3 Disabled Population

According to data from the Department of Empowerment of Persons with Disabilities (2023), Sam Dam Sub-district, Bang Khun Thian District, Bangkok, has the highest number of registered disabled individuals in Bangkok. There are 2,846 registered disabled persons, which can be categorized by type of disability as shown in Table 4.1.

Table 4.1 Number of Disabled Persons by Type of Disability in Sam Dam Sub-district, Bang Khun Thian District, Bangkok

Types of Disabilities	**Gender**	**Number (of People)**	**Total Number (of People)**
1. Visual Impairment	Male	70	149
	Female	79	
2. Hearing or Communication Impairment	Male	206	464
	Female	258	
3. Movement or Physical Impairment	Male	689	1,438
	Female	749	
4. Mental or Behavioral Impairment	Male	113	197
	Female	84	
5. Intellectual Impairment	Male	115	183
	Female	68	
6. Learning Impairment	Male	41	56
	Female	15	
7. Autistic Impairment	Male	53	63
	Female	10	
8. Multiple Disabilities	Male	182	294
	Female	112	
	Male	1	2
	Female	1	
Total number			2,846

Source: Adapted from the Department of Empowerment of Persons with Disabilities (2023).

The statistics show that in the Sam Dam Sub-district, Bang Khun Thian District, Bangkok, the highest number of people with disabilities have mobility or physical impairments, totaling 1,438 individuals. This is followed by hearing or communicative impairments with 464 individuals, and complex disabilities with 294 individuals. The least common type of disability is those whose disability type cannot be specified, with a total of 2 individuals.

4.2 General Information of Key Informants

The key informants used for data collection through in-depth interviews totaled 18 individuals. Some are persons with disabilities themselves, while others are involved in and have experience with the care of severely disabled individuals within families. This includes people with disabilities, families caring for disabled individuals, academics, experts from government agencies, and experts from non-governmental organizations or civil society organizations specializing in disability. Details of severely disabled individuals are presented in Table 4.2.

Table 4.2 General Characteristics of Key Informants for Severely Disabled Individuals

No.	Pseudonym	Age	Type of Disability	Cause of Disability
1.	Ms. Pim	73	Bedridden, unable to walk	Cerebral artery stenosis
2.	Mrs. Phan	68	Bedridden, unable to walk, but can sit up occasionally	Cerebral artery occlusion
3.	Miss Pid	45	Bedridden, unable to walk	Brain and spinal cord disability
4.	Mrs. Pikul	70	Bedridden, unable to walk, but can sit up occasionally	Fractured hip from a fall
5.	Mrs. Pian	69	Bedridden, unable to walk	Cerebral hemorrhage with subarachnoid bleeding
6.	Mr. Phon	58	Bedridden, unable to walk, but can sit up occasionally	Motorcycle accident

From Table 4.2, it is shown that the key informants who are severely disabled individuals under family care for 3 years or more include those with severe disabilities such as being bedridden and unable to walk, or some who are unable to walk but can sit up occasionally. The causes of disability include cerebral artery stenosis, cerebral artery occlusion, brain and spinal cord disability, fractured hip from a fall, cerebral hemorrhage with subarachnoid bleeding, and motorcycle accidents, with a total of 6 individuals. In addition, the key informants also include families who care for severely disabled individuals, with details presented in Table 4.3.

Table 4.3 General Characteristics of Key Informants (Key Informants) of Families Caring for Severely Disabled Individuals

No.	**Pseudonym**	**Age**	**Relationship to the Disabled Person**	**Occupation**
1.	Miss Korn	32	Grandchild	Unemployed
2.	Miss King	43	Child	Security guard
3.	Mr. Krung	65	Father	Selling goods (freelance/contract work)
4.	Mrs. Kanya	37	younger brother/sister	Salesperson / Selling goods
5.	Mrs. Kaew	34	Grandchild	Unemployed
6.	Mrs. Karn	45	Child	Security guard

From Table 4.3, it is shown that the key informants who are family members caring for disabled individuals, providing care for their physical, emotional, and welfare needs for over 3 years, include fathers, children, grandchildren, and younger siblings of the disabled. Their occupations include freelance work, selling goods, and unemployment, with a total of 6 individuals.

The final group of key informants includes academics, experts from government agencies, and experts from non-governmental organizations or civil society organizations, with details presented in Table 4.4.

Table 4.4 General Characteristics of Key Informants (Key Informants) in the Groups of Academics, Government Experts, and Non-Governmental or Civil Society Experts

No.	Pseudonym	Age	Type of Expertise	Occupation
1.	Mrs. Lada	65	Academic	Professor at a public university
2.	Mr. Chatchai	63	Academic	Independent scholar
3.	Mrs. Pun	49	Expert from a government agency	Head nurse at a public health service center
4.	Mrs. Pawinee	46	Expert from a government agency	Nurse at a primary health care facility
5.	Mrs. Piyawan	58	Expert from a non-governmental organization	Private social worker
6.	Mr. Udom	53	Expert from a non-governmental organization	President of the Disabled Parents Association

From Table 4.4, it is shown that the key informants in the groups of academics, experts from government agencies, and experts from non-governmental or civil society organizations total 6 individuals, with details as follows: 1) Academics: These are individuals with experience in teaching, research, or writing academic textbooks for over 3 years, including a professor at a public university and an independent scholar, totaling 2 people. 2) Experts from Government Agencies: These are individuals with experience in working on or setting policies, plans, or laws related to disabilities for over 3 years, including a head nurse and a nurse in a government agency, totaling 2 people. 3) Experts from Non-Governmental or Civil Society Organizations: These are individuals with experience in working on or setting policies, plans, or laws related to disabilities for over 3 years, including a private social worker and the president of the Disabled Parents Association, totaling 2 people.

Therefore, the qualifications of the key informants mentioned above reflect that they are suitably qualified to provide detailed and in-depth information on the issues being studied. Each informant is an information-rich case, possessing comprehensive knowledge on the care of severely disabled individuals by families, including aspects of physical care, emotional support, welfare rights, and state regulations and policies.

4.3 The Situation of Caring for Severely Disabled Individuals by Families

Family care for severely disabled individuals involves different types of care, sources of knowledge for caregiving, and notable caregiving challenges as follows:

4.3.1 Types of Care for Severely Disabled Individuals

The study identified four types of care for severely disabled individuals as follows:

4.3.1.1 State Care for Severely Disabled Individuals

State care for severely disabled individuals follows the concept of institutional care, featuring clear forms, procedures, and processes (Tunyaluk Roongsangjun, 2020). Various services support families to assist them in caring for disabled individuals, including hospitals, public health service centers, public health volunteers, village health volunteers, social development and human security volunteers, personal assistants, and protection and development centers for disabled individuals. These services often provide necessary items and equipment such as diapers, wheelchairs, canes, walkers, hearing aids, rice, and dry food to reduce the burden on families caring for disabled individuals and to mitigate caregiver burnout or fatigue. Caregivers often face significant impacts due to their roles. As Ms. Piyawan (a pseudonym, 2024: Interview) noted, “Some caregivers must take leave, quit their jobs, or resign to care for one disabled person, resulting in a loss of income for family support, making them feel disoriented.” State agencies offer the following support to families: 1) Equipment 2) Knowledge and skills This support aims to strengthen families, enabling them to provide long-term care. Public health volunteers, village health volunteers, and personal assistants, trained in public health and disability care, help with monthly home visits, which can occur up to eight times a month for families facing significant care challenges or for those with severely disabled members.

Caring for severely disabled individuals requires specialized knowledge and must be performed by professionals because the care should be intensive. Volunteers possess only basic knowledge and skills. According to the concept of innovative care, those who assist families in caring for disabled individuals must work as a team and be equipped with health care tools. The formation of a care team should involve health care professionals from various fields working collaboratively and sharing responsibility. The care team must have specific knowledge and skills to continuously support behavioral changes and accept their roles and responsibilities. Additionally, there must be a paradigm shift in caregiving (Jirawat Thewawatpakorn et al., 2021). This aligns with Mr. Chatchai's (a pseudonym, 2024: Interview) view that "care must be specialized and intensive, but there is currently insufficient knowledge, and policies have not yet reached that point." Ms. Poon (a pseudonym, 2024: Interview) explains, "Professionals such as doctors, nurses, physiotherapists, psychologists, and social workers provide consultations and conduct home visits when serious problems arise or refer the disabled to protection and development centers (shelters)." Therefore, when volunteers encounter severely disabled individuals with specific problems or needs, they report the information to the public health service center, as Ms. Pawinee (a pseudonym, 2024: Interview) shared.

"In Bangkok, there are 69 public health service centers under the Bangkok Metropolitan Administration's Health Department. These centers employ medical professionals from various fields, including doctors, nurses, physiotherapists, psychologists, and social workers. The service areas are divided to provide care to the public. If a disabled individual has relatives, the protection and development centers (shelters) will not accept them for services. Severely disabled individuals without relatives have to wait a long time for services due to the limited facilities and staff available at these centers, which are insufficient to meet the needs and address the problems."

4.3.1.2 Community Care for Severely Disabled Individuals

Institutions or agencies that support the care of disabled individuals include several entities, one of which is the "community." This approach aligns with the concept of deinstitutional care, emphasizing a community-based model (Rapeepan Kumhom & Tunyaluk Roongsangjun, 2019). Communities play a role in supporting families in caring for disabled individuals. In Bangkok, its surrounding areas, or other large cities, communities where everyone knows each other can temporarily assist in caring for disabled individuals when relatives need to attend to other matters. However, such close-knit communities are becoming rare. Ms. Poon (a pseudonym, 2024: Interview) stated, "In Bangkok or large cities, society tends to be more individualistic or consists of nuclear families, such as in gated communities or vertical communities, unlike rural areas. This makes it challenging to implement any processes for disabled individuals." Communities have a role in caring for disabled individuals, essentially acting as a substitute for families. This can be done occasionally when community members are available to help. If community care is provided by community volunteers, the quality of care may vary depending on the volunteers' dedication. As Ms. Piyawan (a pseudonym, 2024: Interview) noted, "Community care through community rehabilitation centers is effective because multiple people who understand the needs of disabled individuals provide care." However, this type of care, which includes physical rehabilitation, is rare in communities in Bangkok and other large cities, as explained by Ms. Piyawan (a pseudonym, 2024: Interview).

"In the way of life in Bangkok, it's very much every person for themselves. Even neighbors might not know that someone nearby has a disability. In gated communities, people tend to think that it's not their business and avoid getting involved. However, in slum communities, where life is genuinely difficult, there are community committees. When these committees learn about someone's struggles, they make an effort to check on those in hardship, but their assistance is limited to 'a level of charity' only."

Therefore, if disabled individuals and their families live in a strong community, they will receive good support and assistance in caregiving. However, expecting families to care for disabled individuals on their own, without any supporting systems, makes caregiving very challenging. As Mr. Chatchai (a pseudonym, 2024: Interview) explained:

“In cases where parents or family caregivers of disabled individuals are unable to provide care or are worried about who will care for the disabled person after they pass away, there is a need for some system, such as community welfare, to offer support. Community care must involve the design of service units and certain innovations, such as emergency homes where professional caregivers with specialized knowledge and expertise in caring for severely disabled individuals can provide care.”

4.3.1.3 Private Care for Severely Disabled Individuals

Private care for severely disabled individuals tends to be more expensive than family-provided care. Costs vary based on the type of service, such as single rooms, double rooms, shared rooms, air-conditioned rooms, or fan rooms. Additionally, the medical condition of the disabled individual affects costs. Those who are entirely dependent, requiring tube feeding, tracheostomy care, or unable to manage their own bowel movements, incur higher costs than those who can care for themselves and control their bowel movements. Families with sufficient financial means often opt for private care services.

Private care services are provided in two ways:

1) Sending caregivers from private care facilities to the home of the disabled individual. As Ms. Kaew (a pseudonym, 2024: Interview) explained:

“Hiring caregivers from centers that provide services for disabled individuals and the elderly offers two options: having a caregiver stay 24 hours a day, sleeping with the disabled person, or having a caregiver come and go. Employers are responsible for providing all meals for the caregiver, who can either eat with the employer or be given money to buy their own food. Payment is made to the center, which then pays the caregiver. The monthly salary ranges from 15,000 to 25,000 baht, depending on the caregiver’s experience.”

2) Sending the disabled individual to stay at a private care facility. As Ms. Kann (a pseudonym, 2024: Interview) stated:

“ Private care facilities go by various names, such as care centers, nursing care, and nursing homes. I once sent a disabled person to such a facility when they first became unable to care for themselves or move, based on a relative's recommendation. There are two types of services: the first involves the disabled person staying at the facility 24 hours a day, including all meals at the center. The second is a day-care option. Costs range from 18,000 to 40,000 baht per month, depending on the severity of the disability and the individual's ability to care for themselves. Additionally, there are other expenses such as diapers, food or milk, suction tubes, rubber gloves, and wound care supplies."

4.3.1.4 Family-Based Care for Severely Disabled Individuals

Family-based care for severely disabled individuals follows the deinstitutional care concept, known as the Family-Based Model (Rapeepan Kumhom, & Tunyaluk Roongsangjun, 2019). This approach is crucial because families are the first to be close to the disabled individual, encountering problems firsthand and providing the quickest assistance. Families have blood relations, emotional bonds, love, and closeness with the disabled person, which aligns with Epstein et al.'s (1982) family management concept. This concept emphasizes that families have emotional ties, demonstrating concern and appreciation for each other, which are factors that promote effective family care for disabled individuals. Key factors include maintaining good relationships among family members, having enough members to share the caregiving responsibilities, and having sufficient financial resources to cover the high costs of care. As Mrs. Lada (a pseudonym, 2024: Interview) explained:

"There are three key factors in caring for individuals with severe disabilities: 1) Family relationships: Families with good relationships tend to have better acceptance and care for disabled individuals compared to those with poor relationships, conflicts, or distance. 2) Family size: Families with more members have a larger pool of people to help with caregiving on a rotating basis, so the care does not fall solely on one person. 3) Financial status: Families with better financial resources can obtain better support for caring for disabled individuals compared to those with limited resources."

Additionally, families have social expectations and societal norms regarding the care of family members, whether they are children, the elderly, the sick, or disabled. They all require care, support, and assistance from the family. As Mr. Chatichai (pseudonym, 2024: Interview) mentioned, "The principle of caring for disabled individuals is to have them remain within the family and be a part of the family." Thus, the family plays a crucial role in caring for disabled individuals, especially those with severe disabilities who are unable to care for themselves. Families are essential in providing this care. Ms. Pun (pseudonym, 2024: Interview) commented:

"Family is the most crucial factor or support. The family will take care of each other. Disabled individuals cared for by the family receive the best care. If someone else is responsible, the emotional connection and relationship will be less compared to the family, which can lead to problems in providing lifelong care 'lack of sustainability.' Family care begins with 'love,' which is why it can be sustained and indicates 'sustainability."

Furthermore, Ms. Piyawan (pseudonym, 2024: Interview) stated, "Families will understand and have better emotional bonds than care provided by others." However, if the family does not understand the care required or refuses to care for the disabled individual, the person might not want to stay with the family. Common issues include families unprepared to care for certain types of disabilities, such as individuals with autism who might exhibit severe behaviors or mood swings that could lead to property damage. If the parents or caregivers are elderly, they may not be able to manage these behaviors. Similarly, if the disabled person cannot move independently, elderly caregivers may struggle with physical tasks like lifting or moving the individual. In cases involving cognitive impairments, medical supervision might be needed for medication management or treatment, due to side effects like seizures. As Mr. Chatichai (pseudonym, 2024: Interview) mentioned, "Caring for severely disabled individuals solely by the family may not be sufficient. Families need additional knowledge and supportive services to aid in caregiving."

4.3.2 Sources of Knowledge for Caring for Disabled Individuals

Caring for individuals with severe disabilities requires specific knowledge because these individuals have complex problems and needs. Therefore, caregivers must be well-prepared with knowledge to provide appropriate care. Sources of knowledge for caring for disabled individuals include:

4.3.2.1 Hospitals

Hospitals are a primary source of knowledge for families caring for disabled individuals, gained through visits to healthcare providers. Hospitals have a range of professionals, including doctors, psychiatrists, nurses, physical therapists, psychologists, occupational therapists, hydrotherapists, nutritionists, and social workers. They provide information on diseases, medications, exercise, self-management of conditions, and various benefits that disabled individuals should receive, as well as mental health support. The extent of these services varies between hospitals. Due to the high volume of patients, hospitals focus primarily on medical treatment, medication, and physical therapy specifically for patients receiving hospital services. This includes both outpatient services, where patients visit the hospital for treatment and then return home, and inpatient services, where patients stay in the hospital for a period. Once treatment ends and the patient returns home, they no longer receive these services from the hospital. Consequently, it becomes the responsibility of relatives to learn, practice, and manage the care at home. In this context, many relatives often forget the care techniques, perform them incorrectly, or are unfamiliar with them, leading to problems in providing care. As Ms. Pun (pseudonym, 2024: Interview) mentioned, “When disabled individuals return home, some hospitals provide pamphlets for relatives to study at home, and some hospitals have home health care centers where hospital staff visit the home to provide guidance while the disabled person is at home. Such services help alleviate many issues related to caring for disabled individuals.” Additionally, there is the Sirindhorn Rehabilitation Institute, which specializes in rehabilitation and physical therapy for disabled individuals. This institute assists both disabled individuals and their caregivers at home. As Ms. Piyawan (pseudonym, 2024: Interview) explained:

“The Sirindhorn Rehabilitation Institute is a central hub for disseminating knowledge on caring for individuals with severe disabilities. It produces educational materials and offers training courses for both disabled individuals and their families, whether the disability is congenital or acquired through accidents or illnesses such as stroke or brain hemorrhage. People can schedule appointments to receive training in self-care or caregiving skills, daily living activities, and rehabilitation. The training in caregiving requires the presence of relatives, who will then return to live together and apply the skills learned."

4.3.2.2 Public Health Service Centers

Public health service centers are another organization involved in home visits within their designated community areas. When they encounter disabled individuals, they provide guidance and knowledge on caring for disabled individuals, including physical care, emotional and mental health, and entitlements and welfare. This aligns with the information provided by Ms. Pun (pseudonym, 2024: Interview), who stated:

"Public health service centers offer physical care knowledge through nurses and physical therapists. For emotional and mental health, they have psychiatric nurses or psychologists and social workers who provide counseling, advice, encouragement, and empowerment to disabled individuals and their families. Regarding entitlements and welfare, social workers at the centers provide counseling, advice, and referrals to other agencies that offer welfare services, according to the needs or entitlements that disabled individuals and their families should receive. Welfare services for disabled individuals include vocational grants, environmental adaptations, housing, assistive devices, diapers, and various other essential supplies."

Although public health service centers provide valuable knowledge and support for families caring for disabled individuals, there are some limitations. As Ms. Pavee (pseudonym, 2024: Interview) noted, "There are limitations such as the inability to provide knowledge to every household with disabled individuals, particularly in gated communities, condos, or apartments where privacy is high, making it difficult to identify which homes have disabled members. Additionally, some families may be unaware of these services or may miss out on them due to working during the day."

4.3.2.3 Volunteers

In Bangkok, there are several groups of volunteers involved in caring for disabled individuals, including Public Health Volunteers (PHV) from the Department of Health, Bangkok Metropolitan Administration, Village Health Volunteers (VHV) affiliated with the Ministry of Public Health, Social Development and Human Security Volunteers (SDHSV), and Personal Assistants (PA) under the

Department of Promoting and Developing the Quality of Life for Disabled Persons, Ministry of Social Development and Human Security, among others. These volunteer groups receive training in public health, disability care, and other relevant areas according to their specific roles, which may vary. Volunteers are typically from the local community and often perform home visits to provide information tailored to the individual and family's needs and circumstances. They also supply essential items for caring for disabled individuals, such as diapers, wheelchairs, walkers, canes, respiratory aids, oxygen, and dry food supplies. Additionally, volunteers may have other duties as explained by Ms. Pun (pseudonym, 2024: Interview), who noted, "Volunteers also provide general knowledge and awareness based on social issues, such as providing information on COVID-19 prevention during the pandemic or educating about mosquito prevention and control during the rainy season."

4.3.2.4 Family Members, Relatives, Friends, and the Community

Family members, relatives, friends of the disabled individual, or neighbors within the same community provide knowledge based on their experience in various aspects of caregiving. This includes physical care such as repositioning, physical therapy, nutritious food, medications, herbal remedies, and alternative medicine (Mr. Krung, a pseudonym, 2024: Interview). This knowledge may be acquired through social media (Mr. Phon, a pseudonym, 2024: Interview) or previous experiences. Some individuals may also have direct experience in caregiving. Additionally, there is a practice of sharing caregiving equipment among community members. As Ms. Korn (a pseudonym, 2024: Interview), a key informant, stated: "Most of the knowledge about caring for disabled individuals comes from relatives and friends who have previous caregiving experience. They also share resources like diapers, wheelchairs, beds, and suction machines. If someone is busy, they can ask others to help with caregiving tasks, such as lifting, feeding, and other forms of assistance."

4.3.2.5 Social Media

Currently, accessing knowledge sources is very easy through social media platforms such as Line, Facebook, TikTok, and other various platforms. These sources provide useful information for caring for disabled individuals at home. As Mr. Phon (a pseudonym, 2024: Interview) mentioned: "The knowledge obtained includes information on caring for disabled individuals, dietary recommendations, medications, supplements, vitamins, medical services, alternative medicine, exercise, physical therapy, and various welfare rights.” However, caution is needed when using these media sources as they can vary in reliability. Some information might be accurate and beneficial, but there is also the risk of encountering unreliable sources. Additionally, even if the information is accurate, there may be side effects if applied to disabled individuals with specific chronic conditions or different physical states. Therefore, it is essential to critically evaluate and not blindly follow dietary, medicinal, or therapeutic recommendations provided by these sources.

4.3.2.6 Members of Associations and Disability Groups

Some disabled individuals and their families receive care knowledge from informal peer groups and organized groups such as associations, disability clubs, or parent groups for the disabled. These groups serve as important sources of knowledge, offering information on various aspects of care, including: Care techniques such as turning, lifting, and moving disabled individuals. Physical therapy. Medication, diet, and herbal remedies. Thai and Chinese traditional massage. Psychological support, including meditation, emotional control, understanding behaviors and limitations of disabled individuals, and providing emotional encouragement for both the disabled person and their caregivers (Mr. Chatichai, a pseudonym, 2024: Interview). Knowledge about disability rights and welfare. This support represents a “peer-to-peer” approach. Additionally, these groups emphasize communication, such as how to change positions, assist with eating, and involve the disabled individual in choosing their food and clothing (Ms. Piyawan, a pseudonym, 2024: Interview). They also stress the importance of maintaining privacy, ensuring that activities such as changing clothes, using the toilet, or wearing diapers are conducted discreetly and respectfully, avoiding any unnecessary exposure of the disabled person’s body (Ms. Phawinee, a pseudonym, 2024: Interview).

4.3.3 Problems in Caring for Severely Disabled Individuals by Families

Caring for severely disabled individuals presents several challenges, including economic issues, physical care, emotional and psychological aspects, welfare rights, and problems faced by caregivers. These challenges are detailed below:

4.3.3.1 Economic Problems of the Family

For individuals who become disabled later in life, such as those who suffer accidents or illnesses like a stroke, which result in severe disability and an inability to care for themselves, economic challenges can be significant. Their ability to perform daily activities, measured by Activities of Daily Living (ADL), may range from 0 to 6, where 0 indicates complete dependence and higher numbers indicate increasing self-sufficiency. The ADL scale ranges from 0 to 11.

For working-age disabled individuals, this situation is particularly problematic as it leads to a loss of income, especially if they were the primary earners in their families (Ms. Phawinee, a pseudonym, 2024: Interview). Whether the disability is congenital or acquired later in life, families face similar economic issues. These include necessary living expenses such as wound care supplies, diapers, wheelchairs, and walking aids (walkers, crutches). Some disabled individuals require specialized feeding methods, which involve additional costs for food preparation equipment, special ingredients, and supplements (e.g., measuring cups, scales, specific vegetables, eggs, oil, powdered milk). This leads to increased expenses. In response, some families adapt by using available household items or local resources as substitutes, such as using alternative vegetables when the required ones are unavailable or substituting other equipment when specific tools are too expensive (Mr. Chatichai, a pseudonym, 2024: Interview). Additionally, caregivers in some families may have to leave their jobs to provide care, leading to economic strain and loss of income (Ms. Poon, a pseudonym, 2024: Interview).

4.3.3.2 Issues in Physical Care of Severely Disabled Individuals

Caring for a severely disabled person begins once medical treatment ends, and the individual is discharged from the hospital to return home. During their hospital stay, family members may visit, help with care, and learn caregiving techniques from hospital staff, including nurses, nutritionists, and physical therapists. Once discharged, families are responsible for providing care at home. Some families provide care themselves full-time, while others might have relatives take turns or assist during hospital visits (Ms. King, a pseudonym, 2024: Interview). Severe disability requires 24-hour care, which often necessitates a caregiver leaving their job to ensure sufficient time for caregiving. In some cases, caregivers continue working while providing care, as no other relatives are available to help. If caregivers cannot work, they face financial difficulties. The care routine includes managing cleanliness, preparing food, and changing diapers, often done before work and after returning home. During the day, caregivers may hire someone from the community or, if funds are limited, request help from a nearby neighbor who has consistently offered support (Ms. Karn, a pseudonym, 2024: Interview).

Most disabled individuals develop pressure ulcers that need regular wound care and dressing changes every morning and evening. Severely disabled individuals have limited or no mobility and require repositioning every two hours. Sometimes caregivers become busy or forget, resulting in pressure ulcers. The severity and depth of these ulcers vary depending on the quality of care (Ms. Kaew, a pseudonym, 2024: interview). For example, some disabled individuals whose caregivers must care for them alone or also need to work, are repositioned in the morning before the caregiver goes to work. During the day, the caregiver might come back to feed and reposition them or ask a friend or neighbor to help. Sometimes, there is no one available to help, and the caregiver only repositions them again in the evening. This leads to pressure ulcers that require daily wound care every morning and evening, increasing the costs of wound care supplies such as ointments, gauze, and Micropore tape. In addition to repositioning, it is necessary to support the disabled person to sit up occasionally to change their posture (Ms. Korn, a pseudonym, 2024: interview). Besides repositioning, physical therapy for severely disabled individuals is crucial. If not done, their limbs become stiff and contract. Some individuals have contracted hands to the extent that their long nails dig into their palms, causing bleeding (Ms. Korn, a pseudonym, 2024: interview). Therefore, frequent stretching and physical therapy are essential. Without regular physical therapy, the limbs of disabled individuals can become permanently contracted, a condition known as joint contracture (Ms. King, a pseudonym, 2024: interview).

Disabled individuals must take numerous medications, which they obtain from hospitals. The most challenging aspect is visiting the doctor at the hospital, as it is difficult to travel there. Ms. Kaew (a pseudonym, 2024: interview) mentioned:

"When taking a disabled person to the hospital to see a doctor and get medication, I have to ask a relative with a car to take us and pay for the vehicle and fuel. Sometimes, I hire a taxi that we know because regular taxis usually don't accept us. Alternatively, we rent a private car, van, or private ambulance, which costs 1,500 baht per trip, totaling 3,000 baht for a round trip. Upon reaching the hospital, we have to wait a long time for our turn, and the hospital often schedules frequent appointments because severely disabled individuals need to see multiple specialists due to various complications."

In addition to taking medication and visiting doctors, disabled individuals use diapers and absorbent pads for excretion. If the disabled person is male, he might use regular plastic bags for urination (Ms. Kann, a pseudonym, 2024: interview). If diapers are used without proper ventilation, the skin in that area can develop rashes and irritation (Ms. King, a pseudonym, 2024: interview). Furthermore, various essential and expensive equipment is needed to care for disabled individuals, such as hospital beds, wheelchairs, canes (umbrella canes, crutches), suction machines, oxygen machines, ventilators, cooking equipment, wound care supplies, and suction tubes. Therefore, it is evident that caring for disabled individuals requires many necessary and costly items. Families might purchase these items themselves, borrow from relatives or acquaintances, request or borrow from hospitals, ask for donations from public health centers (PHCs), volunteers from public health (VPHs), social development volunteers (SDVs), community development workers (district offices), and foundations, associations, and clubs for disabled individuals (Ms. Korn, a pseudonym, 2024: interview).

Caring for the diet of individuals with severe disabilities is crucial. Ms. Kan (a pseudonym, 2024: interview) provided the following information: "Some disabled individuals can feed themselves, while others need their caregivers to prepare their food. This includes regular meals and blended foods administered through a feeding tube via the nose. For blended food, caregivers typically prepare a large batch at once, store it in the refrigerator, and reheat it when needed. Each batch lasts about 3-4 days, meaning they prepare blended food twice a week." If they don't prepare it themselves, they can purchase it from the hospital's nutrition department. Some hospitals sell it, but it is more expensive than making it at home. Some families may supplement blended food with nutritional formula powders such as Ensure, Isocal, and Boost Optimum, though these are costly (Ms. Korn, a pseudonym, 2024: interview).

Additionally, environmental factors, particularly climate conditions, significantly impact individuals with severe disabilities and require close attention due to their effects on health and physical condition. Ms. Pim (a pseudonym, 2024: interview) mentioned, “Weather conditions during different seasons greatly affect the physical condition of disabled individuals. During the summer, the heat causes rashes, and if a fan or air conditioning is used continuously, it can lead to pneumonia. The humid rainy season also results in pneumonia and makes infections more likely. In the winter, if it gets very cold, the skin becomes dry and itchy.”

4.3.3.3 Problems in Psychological Care for Severely Disabled Individuals

Some disabled individuals struggle with accepting their disabilities, often perceiving themselves as merely ill and in need of treatment, with the expectation that their condition will improve and eventually be cured. Ms. Pawinee (a pseudonym, 2024: interview) stated, “Not accepting their disability leads some disabled individuals to refuse to register as disabled and to not use services available for disabled people.” This refusal to register as disabled results in them not having a disability card and thus not receiving disability benefits. Immediate registration is not possible after the onset of disability; doctors wait six months after diagnosing the disability to monitor the condition as some may improve. It is also observed that some families face similar acceptance issues, sharing the same expectations as the disabled individuals that their condition will improve, and they will eventually regain the ability to stand and walk as before. During the initial period of discovering the disability, both the disabled individuals and their families experience significant adjustment problems due to the rapid changes impacting their lives. They are often unsure how to adapt to these changes, how to behave, and how to provide care. Mr. Pon (a pseudonym, 2024: interview) mentioned, “Disabled individuals must cope with multiple losses and lifestyle changes, including changes in employment, finances, emotions, and mobility.” For families, time management and organization are crucial. Effective management can help reduce adjustment problems, psychological issues, and feelings of discouragement and frustration (Ms. Piyawan, a pseudonym, 2024: interview).

Severely disabled individuals often feel that they are a burden, which diminishes their self-esteem and leads to numerous psychological issues, such as stress, anxiety about being abandoned, depression, and feelings of hopelessness (Ms. Phan, a pseudonym, 2024: interview). Some individuals have not left their rooms or houses since becoming disabled, have no one to talk to, and do not meet friends or others. Ms. Phan (a pseudonym, 2024: interview) shared, “Disabled individuals want their relatives to take them out, for example, to the provinces or just around the community. They want to exercise.” Some are reluctant to go out because they feel ashamed that they can no longer walk as they used to and feel like a burden to their relatives. Additionally, some disabled individuals do not want to go out because they feel pity for their relatives, as Ms. Phian (a pseudonym, 2024: interview) mentioned, “Disabled individuals feel pity for their relatives and do not want to burden them with the care and expenses. Sometimes they express a wish to die.” Despite this, most disabled individuals still desire visits from others, to have someone to talk to, to receive small gifts, or to enjoy their favorite foods. Ms. Pun (a pseudonym, 2024: interview)

“When I visit homes, I often find that disabled individuals look delighted. Some who can speak call out several times when I pass through the community. When I visit and talk with them, they are eager to engage in conversation and share various stories, both related and unrelated to their health care.”

Additionally, disabled individuals greatly need love, concern, and attention from their family members. Sometimes, disabled individuals may exhibit different ways of seeking attention. If they do not receive adequate love, concern, and attention, their physical condition may deteriorate, such as poor cleanliness, pressure sores, stiff and contracted limbs due to a lack of physical therapy, signs of depression, slow developmental progress, or worsening disability. Some may express their distress through outbursts, violence, or throwing objects (Ms. Pun, a pseudonym, 2024: interview). Effective communication plays a crucial role in addressing the psychological issues of disabled individuals. Communicating love and concern, and showing respect to disabled individuals can make a significant difference. For example, when lifting or moving a disabled person, it is important to inform them beforehand. Allowing disabled individuals to participate in choosing their food, clothing, bedding, and other personal items is essential. Respecting their privacy, such as during clothing changes, bathing, or personal care, is also important, and these activities should be conducted in a private and discreet manner (Ms. Piyawan, a pseudonym, 2024: interview).

4.3.3.4 Issues with Disability Welfare for Severely Disabled Individuals

Most disabled individuals and their families can access disability rights, National Health Insurance (Golden Card), and social security benefits. However, some disabled individuals remain unaware of their entitlements or cannot access these benefits. Mr. Chatchai (a pseudonym, 2024: interview) stated:

“In the case of the Golden Card, we see that among the 70 million population, 95% of disabled individuals receive Golden Card benefits. When a family has a disabled member, the first thought is usually to take them to see a doctor or go to the hospital as a matter of routine. When they visit a doctor or healthcare staff at the hospital, the physician will inquire about their condition and register them in the system because medical expenses need to be billed. Thus, 95% of disabled individuals out of over 2 million are included in the Golden Card system. The remaining 5% are those who do not have access, such as individuals without anyone to take them to see a doctor or to apply for a disability card. These individuals may stay at home and fail to report their information.”

Additionally, there are instances where disabled individuals and their families are unaware of the available loans for vocational activities, home improvement loans to accommodate disabilities, and disparities in disability allowance amounts. Mr. Chatchai (a pseudonym, 2024: interview) remarked: “Some individuals receive 1,000 baht, while others receive 800 baht. The amount should be uniform for everyone, similar to a universal welfare system, with each person receiving 1,000 baht.” Furthermore, there are issues with welfare services for severely disabled individuals who lack family support. Some of these individuals need to be admitted to disability protection and development centers (disability care institutions), which have long waiting times. If an individual has severe disabilities, such as being bedridden, unable to feed themselves, and without a national ID card, and if their family is unable to provide care, they may be denied services at these centers (Ms. Piyawan, a pseudonym, 2024: interview).

4.3.3.5 Issues Faced by Caregivers of Severely Disabled Individuals

For family members who act as caregivers for disabled individuals, numerous challenges arise beyond economic issues, income, expenses, and adaptation. Caregivers often face the following problems: 1) Emotional Exhaustion (Burnout): Long-term caregiving without assistance from other relatives can lead to feelings of frustration, hopelessness, depression, and eventually physical illness. 2) Lack of Understanding from Other Relatives: Other family members may not understand the need for certain activities, such as sending the disabled person to school or participating in activities organized by disability associations or community groups. They may perceive these efforts as a waste of time and money. 3) Challenges with Care Techniques and Equipment: After learning caregiving methods from the hospital, caregivers may struggle to recall and apply them at home. They may also lack essential equipment and materials. Ms. Khing (a pseudonym, 2024: interview) shared, “Before the hospital discharged the disabled person, I learned how to prepare blended food for them. When I tried to do it at home, I forgot the methods and didn’t have the complete equipment and ingredients that the hospital provided.” 4) Work Commitments: Family caregivers who work often have limited time to care for the disabled individual. They might only be able to care for them in the morning before work, return at midday to provide meals and reposition the person, and then care for them again in the evening. Alternatively, if the caregiver works far from home, they may need to rely on neighbors or hire someone else to help with feeding and repositioning during the day (Ms. Poon, a pseudonym, 2024: interview).

In addition, caregivers of disabled individuals face mental health issues such as sadness, anxiety, boredom, and exhaustion. These negative feelings can affect the quality of care provided, potentially leading to inadequate care or even physical and emotional abuse of the disabled person. This problem is often experienced by caregivers who are responsible for sole caregiving over long periods without relief. They require support from the government or other relatives to assist with caregiving, as well as assistance with knowledge, financial support, and necessary equipment. (Mrs. Kan, pseudonym, 2024: Interview)

4.4 Guidelines for Caring for Severely Disabled Individuals by Families in Sam Dam Subdistrict, Bang Khun Thian District, Bangkok

Guidelines for caring for severely disabled individuals refer to the methods or approaches established as models for the caregiving process. These guidelines must cover physical care, emotional and psychological support, and welfare rights to ensure that disabled individuals receive good care and have a high quality of life. Caregivers should have model guidelines to follow or adapt in their caregiving practices for the individuals they care for, as follows:

4.4.1 Guidelines for Physical Care of Disabled Individuals

System that consists of groups such as temporary caregivers and community support, and utilizing organizations or agencies like disability protection and development centers and the Bangkok Health Bureau. Online formats, such as telemedicine, are also essential tools for caregiving. Additionally, public awareness campaigns about caregiving for disabled individuals are important. The guidelines for physical care of severely disabled individuals are as follows:

4.4.1.1 Guidelines for Providing Knowledge on Caregiving, Self-Management, Adaptation, and Adjustment for Disabled Individuals Knowledge for caregiving should be provided by hospitals, public health centers, health volunteers (HVs), village health volunteers (VHVs), social development and security volunteers (SDSVs), and personal assistants (PAs). This involves offering information, providing care, or visiting disabled individuals multiple times, especially during the initial period of disability or when discharged from the hospital. This is crucial because disabled individuals and their caregivers may initially lack the knowledge and skills needed for self-management and may struggle to adapt to changes.

4.4.1.2 Temporary caregiver services are crucial when a caregiver is ill, has personal matters to attend to, or needs a break due to fatigue, exhaustion, stress, or burnout. This aligns with the opinion of Mrs. Piyawan (pseudonym, 2024:

Interview), who stated, “Caregivers need time off for personal errands or to rest from caregiving, such as going to the doctor, participating in religious activities, or taking a vacation. The temporary caregiver should be someone specifically trained to care for severely disabled individuals and should be a trusted person who is known to the caregiver.” In other countries, temporary caregiver services are provided as welfare benefits for parents with disabled children or for those who care for disabled individuals. They receive 52 days of temporary caregiver services per year, which amounts to one day per week. No additional costs are incurred. Caregivers can choose the form of temporary care, whether a continuous 3 day period or the entire month. If caregiving needs exceed 52 days, relatives will need to pay for additional temporary caregiving services themselves.

4.4.1.3 Community-Based Care Homes, which are not institutional shelters, involve community participation in the care of disabled individuals and their families. This approach aligns with the community care innovation concept proposed by Ratchanee Sansoen et al. (2012), which highlights the importance of the community in health care and managing disability issues. The approach promotes awareness of risks and problems, support from various community groups, and encourages the formation of groups to improve disability care. The community thus plays a crucial role in health care and managing chronic illness issues, as explained by Mrs. Pun (pseudonym, 2024: Interview), who described it as, “A community-based care home, or a house bought or rented by the state in a residential area or community, with staff providing care services for disabled individuals. These individuals might be those without families or with families that are unable to care for them, with about four individuals sharing a home.” Such facilities should have staff on duty like institutional shelters. This service can assist both disabled individuals and their caregivers, particularly when the caregivers are elderly. Mrs. Piyawan (pseudonym, 2024: Interview) gave an example: “An elderly caregiver, aged 80, may not be able to care for their disabled 60-year-old child. They could use this type of care home service.” In other countries, this type of facility is known as “Accommodation,” where disabled individuals receive 24-hour care and where parents or caregivers can visit. If the parents or caregivers are not too old, they can also take their disabled family members back home. In Thailand, this type of service is not yet available, though there have been similar group home services provided by the government, which have not been widespread. Establishing such community-based care homes would reduce the size of institutional shelters and employ community members as caregivers. Mrs. Piyawan (pseudonym, 2024: Interview) noted, “In Thailand, it could be done easily. For example, some elderly people are left alone when their spouses die or their children move away. If they have more than one room, disabled individuals from the same community could stay there, with volunteers providing care.” Having disabled individuals live together provides them with companionship and the opportunity to share meals.

Additionally, there is a need for “crisis care homes” to provide services in situations where the caregivers of disabled individuals (the disabled individuals’ families) face crises, such as illness, flooding, or fire. These services would be available for those experiencing a crisis for approximately 4-5 days. Mrs. Piyawan (pseudonym, 2024: Interview) explained:

“In Thailand, there are existing facilities with characteristics similar to crisis care homes, such as government-run institutions like child and family shelters and facilities for the homeless. However, they are not equipped to care for disabled individuals because they lack specialized staff trained in the care of disabled individuals or disabled children. In the private sector, the Thai Autism Association has established a ‘Protection Home for Autistic Individuals,’ which provides services but is still essentially a training center. Caregivers who are exhausted from caregiving may leave disabled individuals at the center for half a day, which does not align with the intended purpose of crisis care homes, which are not designed for ‘temporary care’ but for emergency situations. There is also a lack of additional staff training systems. Crisis care homes should be established with seriousness and further development, funded by disability funds, to serve families in sudden illness or loss.”

4.4.1.4 Services for Disabled Individuals Without Relatives or Whose Relatives Cannot Care for Them Services for disabled individuals who do not have relatives or whose relatives cannot care for them may be provided in the form of “foster families” or “adoptive families” for lifelong care. These facilities are not institutional shelters with specialized professionals but rather are community-based family arrangements where disabled individuals are cared for in a family setting. This includes providing 24-hour care by families within the same community. For example, the Thai Autism Foundation operates a home called the “Autistic Protection Home” (Mr. Chatchai, pseudonym, 2024: Interview). The government supports these services by covering the costs of caregiving and compensating the caregivers.

4.4.1.5 Protection and Development Centers for Disabled Individuals (Disability Shelters) must have procedures for providing quick services, expanding service capacity, and having clear and rapid queuing systems. There should also be services available for severely disabled individuals whose relatives are unable to care for them. The system should involve evaluations by professionals who assess the necessity of services for the disabled individuals, ensuring that service provision is based on their quality of life (Mrs. Kan, pseudonym, 2024: Interview).

4.4.1.6 The Role of the Community in Supporting Family Care Communities play a significant role in supporting family caregiving. Currently, Bangkok has over 2,000 established communities where people tend to live independently, often avoiding interaction and fearing strangers who might steal or cause harm. In residential areas such as housing estates, condominiums, and apartments, hospital staff, public health center staff, associations, and clubs must obtain permission from the property management before visiting (Mrs. Pun, pseudonym, 2024: Interview). Additionally, community-based disability care is rare in Bangkok because most community leaders focus more on physical development, such as roads, electricity, and water supply, rather than on disability care. Therefore, communities and community leaders/presidents should prioritize supporting and promoting family caregiving for disabled individuals, as they are part of the community. A community health center should serve as a hub for residents to gather, socialize, and engage in various activities, including health and economic activities. Key personnel include community members who can care for each other, with health volunteers (HV) teaching caregiving methods to assist in the community. The government should support caregiving through compensation, equipment costs, and caregiving allowances. The care services could be divided into two teams: the first team would care for disabled individuals who are not bedridden but can use a wheelchair or walk with difficulty. This could resemble a day care service at the community health center where individuals participate in activities. If relatives lock up their homes and leave their disabled family members with neighbors for meals, these individuals could join activities at the health center, with 5-7 people being cared for by health volunteers. These volunteers would provide meals, help with daily routines, and manage food supplies, with individuals traveling back and forth between their homes and the community center. The second team would provide "proactive" care by visiting bedridden individuals at home, possibly once or twice a week or daily if needed. This includes teaching wound care. The community should support this effort with facilities, common household medications, wound care supplies, crutches, and other necessary equipment (Mrs. Pun, pseudonym, 2024: Interview). Additionally, support should be given to involve disabled individuals and their caregivers in activities such as making donation coins, garlands, paper bags, and funeral flowers (Mrs. Karn, pseudonym, 2024: Interview).

4.4.1.7 Provision of Essential Equipment for Living and Caring for Disabled Individuals There should be support for providing essential equipment and supplies for disabled individuals to meet their needs promptly. For example, there are currently limitations on the distribution of diapers (e.g., Pampers), with a cap of 3 pieces per day per person, regardless of the number of disabled individuals. If a disabled person meets the criteria, there are two levels of assistance based on their Activities of Daily Living (ADL) score: ADL 0-6 qualifies for assistance as they are unable to help themselves or can do so minimally. However, for ADL 6-11, which indicates some level of self-care ability, a medical certificate is required to confirm that the person has urinary incontinence. Regardless of how many severely disabled individuals are bedridden in a household, each eligible person should receive 3 pieces per day, with distribution options being monthly, semi-annual, or quarterly (Mrs. Pun, pseudonym, 2024: Interview). Furthermore, support should extend to other necessary equipment that is not yet provided, such as food blenders for individuals who require feeding through a tube, suction devices for mucus, and pressure sore care equipment (Mrs. Kan, pseudonym, 2024: Interview).

4.4.1.8 Continuity of Care System by the Bangkok Metropolitan Administration the Bangkok Metropolitan Administration's continuity of care system involves transitioning from hospital care to home care for individuals with disabilities who have been treated in hospitals. Upon the conclusion of their treatment, the coordination of their care is transferred to public health centers. A team of staff members and health volunteers will visit the home regularly, at least once a month. If issues arise, such as those related to living costs, employment, or requests for financial aid, coordination will be made with community development workers or social workers at the district office. If a disabled person has no family, coordination will be made with the Disability Protection and Development Center (Disability Shelter). The service system must be efficient, continuous, and include a multidisciplinary team that visits homes with severely disabled individuals multiple times a month. This proactive service approach enhances the strength of disability care (Mrs. Pawinee, pseudonym, 2024: Interview).

4.4.1.9 The telemedicine system, also known as online doctor consultations, is crucial for addressing the difficulties faced by disabled individuals who struggle with traveling to hospitals. According to Mrs. Pawinee (pseudonym, 2024: Interview), who has experience working with severely disabled individuals, many face challenges such as taxis being unwilling to accept them or having high travel costs compared to the general population. In Bangkok, there is a service known as “disabled taxi,” but it is not widely known, and its use involves a complicated process, including downloading and using an application for online service requests. Some disabled individuals or their caregivers are not familiar with this system or may use private ambulances or shuttle services, which can be expensive. In line with Mrs. Pun’s (pseudonym, 2024: Interview) comments on this issue, the “online doctor consultation” system would alleviate the congestion at hospitals, reduce travel costs and time, and eliminate the need for caregivers or relatives to take time off work.

4.4.1.10 Publicizing Support Groups and Networks It is essential to promote awareness about the existence of support groups such as parent groups, associations, clubs, and foundations that provide knowledge, skills, physical assistance, emotional support, and peer help. Communication through platforms like LINE should be established. According to Mr. Krung (pseudonym, 2024: Interview), “Once members join various groups, they become aware of and participate in the group’s activities, creating a network of friends and mutual support.” Additionally, Mr. Udom (pseudonym, 2024: Interview) emphasized that disability groups should be empowered and active in social movements to advocate for, promote, and develop fair and dignified rights and benefits for people with disabilities.

4.4.2 Guidelines for Mental Health Care for People with Disabilities

Guidelines for mental health care for people with disabilities include providing knowledge on preparation, communication, encouragement, relaxation activities, natural support groups, and managing problems faced by individuals with disabilities. These are as follows:

4.4.2.1 Knowledge for Preparation and Adjustment It is essential to provide knowledge on preparing for and managing changes related to physical health, daily living abilities, and work to help individuals adjust and accept their disabilities. Additionally, information should be provided about treatment processes and potential problems to both the individuals with disabilities and their caregivers. As Ms. Pun (pseudonym, 2024: Interview) mentioned, “Organizations providing mental health knowledge and care should include hospitals, public health centers, and various volunteers, with follow-up and home visits (Home Health Care).” Currently, while hospitals may provide preparation services, not all hospitals offer this support. Ms. Karn (pseudonym, 2024: Interview) added that “If individuals with disabilities and their caregivers do not apply for services, they will not receive mental health preparation and care services.”

4.4.2.2 Stress-Relief Activities for People with Disabilities Stress-relief activities for people with disabilities at the community and medical levels include promoting activities that allow individuals with disabilities to socialize, share meals with friends, relatives, and others, go on outings, and receive relaxation massages. Such activities can help reduce stress and boredom for those with severe disabilities, and positively impact their motivation to live, maintain health, and rehabilitate (Ms. Piyawan, pseudonym, 2024: Interview).

4.4.2.3 Effective Encouragement Providing effective encouragement is essential for motivating individuals to live actively, exercise, engage in physical therapy, care for themselves, and feel comfortable. This aligns with the views of Ms. Pis (pseudonym, 2024: Interview) and Ms. Lada (pseudonym, 2024: Interview), who shared that “Communication and encouragement help individuals with disabilities feel that they are not a burden, are cared for, and are assured that they will not be abandoned by family, relatives, and friends. Especially, caregivers who are spouses are often very worried.” This is because individuals with disabilities may experience negative feelings, embarrassment, and the sense of being a burden, which affects their social interaction and participation in community activities (Knafl et al., 2012). Ms. Phan (pseudonym, 2024: Interview) discussed “empowerment and self-esteem building for people with disabilities through support from caregivers, spouses, family members, friends, and professionals with specific expertise in mental health therapy, especially in cases of severe distress.”

4.4.2.4 Importance of Communication with People with Disabilities It is crucial to communicate with people with disabilities, especially when lifting, moving, or assisting them with daily activities such as bathing, brushing teeth, using the toilet, changing clothes, and diapers. Clear communication is necessary because sometimes individuals with disabilities may not be prepared for sudden movements and can become frightened (Ms. Pim, pseudonym, 2024: Interview). Additionally, respecting the personhood of individuals with disabilities involves seeking their opinions on matters such as food choices, clothing, and accessories, and maintaining privacy during various activities (Ms. Piyawan, pseudonym, 2024: Interview). This respect and consideration contribute to enhancing their self-esteem.

4.4.2.5 Role of Natural and Organized Support Groups Support from natural groups, such as relatives and friends, and organized groups like associations, clubs, and foundations for people with disabilities is important. These groups should play a role in providing emotional support to those who are not part of such groups or unable to participate in activities due to difficulties or other commitments, both for the disabled individuals and their caregivers (Ms. Pim, pseudonym, 2024: Interview).

4.4.2.6 Addressing Community Attitudes Towards People with Disabilities Some individuals with disabilities may exhibit challenging behaviors such as aggression, yelling, or creating disturbances. These behaviors often stem from illness or accumulated psychological stress. Sometimes, neighbors or even relatives may not understand these behaviors, leading to negative attitudes and comments, and a desire to have the person placed in a care facility like a nursing home or a disability shelter (Ms. Pikul, pseudonym, 2024: Interview). Therefore, families caring for individuals with disabilities need to educate the community about the behaviors exhibited by disabled individuals as manifestations of their condition.

4.4.3 Approaches to Disability Welfare Rights

Approaches to the welfare rights of individuals with severe disabilities include methods for accessing financial assistance for disabilities, such as disability benefits, home repair loans, and investment loans. It also involves strategies for accessing basic necessities, promoting awareness of welfare rights, and strengthening group support, associations, and clubs. The approaches are as follows:

4.4.3.1 The right to disability benefits should be equitable and comprehensive, as stipulated by the Disability Quality of Life Promotion and Development Act, B.E. 2550 (2007). This includes benefits for both registered and unregistered disabled individuals (those who have never had a national ID card), and for those facing social disabilities—such as those who have been laid off, faced discrimination, or exploitation. There should also be initiatives to promote employment for people with disabilities and their caregivers, such as community-based home jobs or income-sharing opportunities from vending machines (Mr. Udom, pseudonym, 2024: Interview).

4.4.3.2 The right to access loans or financial assistance for people with disabilities and their caregivers includes home improvements and career development. This is in line with the Ministry of Social Development and Human Security's policy for disability care (Department of Disability Quality of Life Promotion and Development, 2023). Increased loan amounts should align with rising living costs, and disbursements should be prompt to address the needs of disabled individuals and their caregivers (Ms. Pim, pseudonym, 2024: Interview).

4.4.3.3 The right to basic necessities such as diapers, equipment, wheelchairs, canes, and consumables should be automatically provided without the need for an application, as the state is already aware of who is disabled, the nature of their disability, and their location. Provision should be based on need, assessed by professionals in the field of disability (Ms. Pien, pseudonym, 2024: Interview). This is in accordance with Article 25(1) of the Universal Declaration of Human Rights, which states that everyone, whether able-bodied or disabled, has the right to a standard of living adequate for health and well-being, including access to medical care, essential services, and security in times of unemployment, sickness, and disability (United Nations, 2015).

4.4.3.4 Publicizing Access to Welfare Rights Public awareness should be promoted through various channels such as TV, radio, social media—and through state officials visiting and providing care in local areas (Ms. Pikul, pseudonym, 2024: Interview). This ensures that people with disabilities and their caregivers can access rights and welfare services comprehensively and promptly. People with severe disabilities often require specialized care different from other types of disabilities, and services should reflect that specificity. Additionally, those without knowledge or understanding may not access or fully utilize these welfare rights (Ms. Piyawan, pseudonym, 2024: Interview).

4.4.3.5 The right to have officials visit, provide advice, and refer to other services as needed and address issues for people with disabilities equally should be available both during and outside regular working hours. For instance, during evenings or weekends, if issues arise, people might not know where to seek advice or assistance (Mr. Krung, pseudonym, 2024: Interview).

4.4.3.6 The right to be supported by groups, associations, and clubs to provide care for people with disabilities independently of the state should be emphasized. This approach tends to be more flexible and quicker than government services (Ms. Pim, pseudonym, 2024: Interview). This could help reduce the state's role and budget and promote social movements.

Moreover, developing care strategies should be continuous. As Mr. Krung (pseudonym, 2024: Interview) mentioned, "Care for people with disabilities requires officials to visit the field to see the actual problems, listen to feedback on various issues, and understand the needs and expectations of people with disabilities and their caregivers." There should also be increased penalties for abuse or exploitation of people with disabilities, aligning with Ms. Phan's (pseudonym, 2024: Interview) information that "People with disabilities are vulnerable and often exploited by relatives or acquaintances who use them for personal gain." Efforts should also focus on continuously improving the quality of life for people with disabilities by updating laws, enforcing them rigorously, and making regulatory adjustments that facilitate care and protect the rights of people with disabilities. This will strengthen the system and contribute to ongoing improvements in care quality (Jirawat Thewawatpakorn et al., 2021).

4.5 Model for Caring for Severely Disabled Individuals by Their Families

Individuals with severe disabilities often have very limited or no ability to care for themselves and require comprehensive care in all aspects. Through in-depth interviews with key informants, appropriate care strategies for severely disabled individuals were identified and analyzed, leading to the development of a model for caring for such individuals, as outlined below:

4.5.1 Physical Care Model

Severely disabled individuals need knowledge and skills to manage their personal care and daily activities, such as bathing, brushing teeth, toileting, moving, and eating, especially if they require special diets or feeding tubes. For example, knowledge about preparing blended food is crucial (Ms. Krung, pseudonym, 2024: Interview), as disabled individuals cannot perform these tasks themselves, requiring caregivers to assist. Medication management, repositioning, lifting, transferring, physical therapy, and using equipment like wheelchairs or walking aids are also essential skills (Ms. Pun, pseudonym, 2024: Interview). Providing knowledge to both disabled individuals and their caregivers about these changing physical needs is crucial for proper care and to improve the quality of life. Some individuals may experience improved conditions or reduced severity of their disabilities, moving from being bedridden to being homebound (Ms. Piyawan, pseudonym, 2024: Interview). This knowledge can be accessed through various sources, including government agencies, private sectors, civil society, families, friends, communities, and relevant groups or associations, thereby supporting families in effectively caring for disabled individuals.

4.5.2 Emotional and Psychological Care Model

In the early stages of disability, both the disabled individuals and their families face psychological challenges, such as acceptance and fear. Prioritizing emotional and psychological care helps individuals cope with these challenges and adapt effectively. This involves providing counseling, encouragement, empowerment, and self-esteem support for both the disabled individuals and their caregivers (Ms. Lada, pseudonym, 2024: Interview). Having individuals who rotate in caring for the disabled can help reduce stress and caregiver fatigue. Emotional and psychological care should involve both government agencies, such as professionals or specialists, and community members, including community leaders, relatives, and friends, who can provide emotional support (Mr. Udom, pseudonym, 2024: Interview). For severe emotional and psychological issues, immediate help from experts like psychiatrists, psychiatric nurses, or psychologists should be sought (Ms. Kaew, pseudonym, 2024: Interview).

4.5.3 Welfare Rights Model

Ensuring that disabled individuals and their caregivers have access to their entitlements (Ms. Kan, 2024: Interview) based on their needs and situations is crucial. These should not be seen as requests or charitable acts but as welfare that respects the dignity of disabled individuals and provides universal coverage (Ms. Piyawan, pseudonym, 2024: Interview). Welfare should be equitable and accessible, with disabled individuals and their caregivers being aware of and able to easily and quickly access their entitlements, such as assistive devices, beds, wheelchairs, diapers, walking sticks, oxygen machines, respiratory aids, consumables, wound care supplies, disability benefits, loans, and tax reductions (Ms. Pun, pseudonym, 2024: Interview). Additionally, providing work opportunities for disabled individuals and their caregivers to do at home can be beneficial. This helps them make productive use of their time, alleviates the challenges of disability and caregiving, and provides additional income to support their livelihood (Ms. King, pseudonym, 2024: Interview).

Additionally, support for the rights to have caregivers for disabled individuals is necessary when the primary caregivers need to rest, attend to personal matters, or are ill. In cases where the caregiver passes away and no one is left to care for the disabled person, there should be more options beyond institutional care (such as shelters). Systems like foster families and adoptive families should be available as alternatives (Mr. Chatchai, pseudonym, 2024: Interview).

Therefore, the care for severely disabled individuals by families must be holistic, covering various aspects: biological, psychological, spiritual, social, and welfare. This includes: 1) Knowledge 2) Equipment 3) Caregivers 4) Money 5) Groups 6) Community.

CHAPTER 5

CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

The study on the care of individuals with severe disabilities by their families in Samdam Subdistrict, Bangkhunthian District, Bangkok, aimed to achieve three objectives: 1) to investigate the current state of care for individuals with severe disabilities by their families in Samdam Subdistrict, Bangkhunthian District, Bangkok; 2) to develop guidelines for the care of individuals with severe disabilities by their families in Samdam Subdistrict, Bangkhunthian District, Bangkok; and 3) to create a model for the care of individuals with severe disabilities by their families.

This research employed qualitative research methods, collecting primary data through in-depth interviews with key informants, including individuals with disabilities, their caregivers, and experts from both government and non-governmental organizations or civil society organizations specializing in disability, totaling 18 participants. Data was gathered through purposeful sampling, in-depth interviews, and informal observations, as well as secondary data from academic documents, books, theses, and various research papers. The data was then analyzed using content analysis, data categorization, logical reasoning, and inductive summarization.

This chapter will present the study’s findings, discuss the results, and offer recommendations, with details organized under the following headings:

5.1 Conclusions

5.2 Discussion of Results

5.3 Recommendations

5.1 Conclusions

5.1.1 The State of Care for Individuals with Severe Disabilities by Families

5.1.1.1 Types of Care for Individuals with Severe Disabilities

There are four types of care for individuals with severe disabilities:

1) State-Provided Care: This type of care follows the institutional care model, with clear guidelines, procedures, and processes (Thanyaluck Rungsangchan, 2020). Institutions involved in providing care include hospitals, public health centers, health volunteers (HV), village health volunteers (VHV), social development and human security volunteers (SDHVS), personal assistants (PA), and shelters or care facilities for individuals with disabilities. The staff primarily assist by providing necessary items and equipment such as diapers, wheelchairs, crutches, walkers, hearing aids, rice, and dry food. This support aims to alleviate the burden on families caring for individuals with disabilities and to reduce caregiver burnout and fatigue.

2) Community-Provided Care: This type of care aligns with the deinstitutional care model, emphasizing a community-based approach (Rapeepan Kumhom, & Tunyaluk Roongsangjun, 2019). The community plays a role in caring for individuals with disabilities, acting as a substitute for the family on an occasional basis when volunteers are available. However, the quality of care may be inconsistent as it depends on the volunteers. In Bangkok and surrounding metropolitan areas, or in large cities, the community care model can be challenging to implement effectively. This is especially true in settings such as housing estates, condominiums, and apartments where people tend to live more independently and community support structures are less integrated.

3) Care by Private Institutions: This type of care includes two models. The first model involves sending caregivers to the homes of individuals with disabilities, providing either 24-hour care or day care. The second model involves sending individuals with disabilities to private care facilities, which also offer 24-hour care or day care.

4) Family-Provided Care: This aligns with the deinstitutional care model, specifically the family-based model (Rapeepan Kumhom, & Tunyaluk

Roongsangjun, 2019). Family-based care is crucial because the family is the primary group that is closest to individuals with disabilities. They are the first to encounter the problems faced by individuals with disabilities and can provide immediate assistance and care. Families have blood relationships, emotional bonds, love, and closeness with individuals with disabilities. Family members who provide care include parents, children, spouses, siblings, and other relatives. Caregivers may provide 24-hour care alone, or in some families, caregiving responsibilities are rotated among family members.

5.1.1.2 Sources of Knowledge for Disability Care

Caring for individuals with disabilities must be performed by those who possess specific knowledge and skills. The sources of knowledge for disability care include:

1) Hospitals where individuals with disabilities receive treatment: These institutions employ medical personnel such as doctors, psychiatrists, nurses, physical therapists, speech therapists, hydrotherapists, occupational therapists, nutritionists, pharmacists, and social workers.

2) Public health centers in the area where individuals with disabilities reside: Families providing care must contact these centers to receive services. Personnel from public health centers, such as nurses, physical therapists, and social workers, provide knowledge and conduct home visits.

3) Volunteers in the area where individuals with disabilities reside: These include health volunteers (HV) from the Department of Health, Bangkok; village health volunteers (VHV) under the Ministry of Public Health; social development and human security volunteers (SDHSV); and personal assistants (PA) under the Department of Empowerment of Persons with Disabilities, Ministry of Social Development and Human Security. These volunteers provide knowledge on various aspects of care, including physical health, mental health, and rights and welfare.

4) Family members, relatives, friends, and the community: Family members, relatives, friends of individuals with disabilities, or friends of the family, as well as neighbors within the same community who are familiar with the disabled individual or their family, often possess knowledge and experience in

disability care. They may have acquired this knowledge from various sources, particularly regarding physical care such as repositioning, physical therapy, nutrition, medications, herbal remedies, and alternative medical treatments, and they share this information.

5) Social media: Platforms such as websites, Facebook pages, TikTok, Line, and other social media channels disseminate knowledge. However, users must exercise caution as there can be misinformation or inappropriate care advice for individuals with disabilities.

6) Associations and disability clubs: Informal groups (peer groups) or organized groups such as foundations, associations, disability clubs, or parent groups of individuals with disabilities provide care knowledge. They offer guidance on physical care, such as repositioning, lifting, transferring individuals with disabilities, physical therapy, medication, nutrition, herbal treatments, and traditional Thai and Chinese massage. They also provide mental health support, including meditation, emotional control, understanding the behavior, emotions, and limitations of individuals with disabilities, encouragement, psychological counseling for both disabled individuals and their caregivers, and knowledge about rights and welfare. Additionally, they offer self-management principles to caregivers, helping them manage their regular responsibilities while taking on the role of a caregiver.

5.1.1.3 Problems in Caring for Individuals with Severe Disabilities by Families

There are six main problems in caring for individuals with severe disabilities by families:

1) Economic Problems: The family faces financial difficulties because the disabled individual cannot work and earn an income. Additionally, the care of individuals with severe disabilities incurs high expenses.

2) Physical Care Problems: This includes challenges in managing daily activities, feeding, medication, physical therapy, and wound care for individuals with severe disabilities.

3) Mental Health Care Problems: Individuals with severe disabilities may struggle with adaptation, stress, anxiety, depression, feelings of being

a burden, and a lack of emotional stability. These mental health issues can manifest as either withdrawal or aggressive behaviors.

4) Welfare Care Problems: While most individuals with disabilities and their families have access to disability rights, the National Health Security Office (Gold Card) benefits, and social security benefits, there are still some who are unaware of their rights and cannot access them.

5) Caregiver Problems: Caregivers often experience emotional burnout from long-term caregiving without relief or support from other relatives, leading to feelings of boredom, discouragement, and depression. There are also issues with other relatives not understanding the demands of caregiving, caregivers forgetting or not properly applying care techniques learned from hospitals, lack of necessary equipment, and the problem of caregivers needing to work, leaving them with insufficient time to care for the disabled individual.

5.1.2 Guidelines for Caring for Individuals with Severe Disabilities by Families

The guidelines for caring for individuals with severe disabilities by families include aspects of physical care, emotional support, and rights and welfare, as follows:

5.1.2.1 Physical Care

Developing knowledge and skills for self-management and adapting to changes is crucial, especially when caregivers are ill, busy, or need time off for rest. To reduce fatigue, exhaustion, stress, and boredom, there should be a system for temporary caregiving, such as a "crisis care home" or "emergency care home" located within the community. This system would not be a shelter but a community-based service that supports family caregiving. Additionally, essential equipment and supplies for daily living and disability care should be adequately provided. A system for caregiving when relatives are not available, called "foster families" or "adoptive families," should be established. Care should be seamless, providing continuous care from hospitals and care facilities for individuals with disabilities, including clear service procedures and waiting times. Improvements should include the development of online medical consultation systems, known as telemedicine, and public awareness campaigns about established disability groups that can assist and support families in caregiving.

5.1.2.2 Emotional Care

Learning skills and methods for preparing and coping with physical changes in individuals with disabilities is crucial. Engaging in activities that help reduce stress, such as traveling, visiting temples, and participating in important events, can be beneficial. Providing encouragement helps individuals with disabilities stay motivated and engaged in life. Effective communication with individuals with disabilities, promoting exercise, physical therapy, and self-care are important for alleviating their stress. Additionally, addressing community attitudes towards individuals with disabilities and their families is necessary. For instance, behaviors such as aggression, shouting, and noise disturbances can be misunderstood. Families need to communicate that such behaviors are related to the individual’s condition. Finally, caregivers, relatives, and friends should prioritize good communication and respect the privacy of individuals with disabilities, as this promotes dignity and enhances their self-esteem.

5.1.2.3 Welfare Rights Care

The management of welfare rights for individuals with disabilities includes the following: 1) Equal and Comprehensive Disability Benefits: Disability allowances or financial support must be equitable and accessible to all eligible individuals. 2) Essential Supplies and Equipment: Basic needs and necessary equipment such as diapers, wheelchairs, canes, and other consumables should be provided automatically without requiring an application process. 3) Funding or Loans: Financial support for individuals with disabilities and their caregivers, including home modifications and vocational training, should be fair and appropriate to their needs and cost of living. 4) Increased Awareness: Publicize welfare rights more effectively through various media channels such as television, radio, and social media to ensure better access to these rights. 5) Regular Government Visits: State officials should regularly visit the homes of individuals with disabilities, offer continuous support, and assist with accessing additional services as needed. 6) Promoting Disability Groups: Support and empower disability groups, associations, and clubs to enhance non-governmental care options, providing more flexible and responsive care compared to government services.

5.1.3 Model for Caring for Individuals with Severe Disabilities by Families

The holistic model for caring for individuals with severe disabilities by families includes five areas: Biological Psychological Spiritual Social Rights & Welfare Each area encompasses six key components of care: 1) Knowledge: Providing information to individuals with disabilities and their caregivers, which includes daily care routines, wound management, medication administration, safe handling and moving of individuals, physical therapy, wheelchair skills, use of canes and other equipment, exercise, communication, encouragement, and empowerment. 2) Equipment: Essential items for daily living, such as beds, wheelchairs, diapers, canes, oxygen machines, respirators, suction devices, and other medical and consumable supplies. 3) Caregivers: Support from those who help when the primary family caregivers need rest, are busy, or are ill. This includes health volunteers, community volunteers (e.g., village health volunteers), social development volunteers, personal assistants, emergency care homes, foster families, adoptive families, visitations, outings, and telemedicine services. 4) Money: Financial support for individuals with disabilities and their caregivers, including disability allowances, vocational loans, home modifications, and tax deductions. 5) Groups: Support from clubs, associations, foundations, and natural groups that assist individuals with disabilities and their caregivers. 6) Community: Community support including care, provision of equipment, employment opportunities, assistance with lifting and carrying, community attitudes, help during times of caregiver absence, and vigilance for safety.

5.2 Discussion

Based on the study results, several interesting points for discussion emerge:

5.2.1 Current Situation of Family Care for Individuals with Severe Disabilities

The study reveals that families do not care for individuals with severe disabilities alone; they receive support from various societal sectors. The four key sectors are: 1) Government Care for Individuals with Severe Disabilities: This includes support from hospitals, public health centers, health volunteers (e.g., Public Health Volunteers), village health volunteers, social development and human security volunteers, personal assistants (PAs), and disability care and development centers. The government supports both physical and mental care, from the time the individual is hospitalized to their return home. If a caregiving family member passes away, the government steps in to care for the individual by placing them in a disability care and development center. This approach aligns with the principles outlined by Rapeepan Kumhom and Tunyaluk Roongsangjun (2019), where government care begins when disability is first identified and continues throughout the individual’s life. This is in accordance with the Universal Declaration of Human Rights (Article 25(1), which states that everyone has the right to an adequate standard of living to ensure health and well-being and to receive equal services from the state (United Nations, 2015). The government transitions from being the primary service provider to supporting and promoting family-based care, moving from institutionalization to deinstitutionalization as outlined by Tunyaluk Roongsangjun (2020). 2) Community-Based Care for Individuals with Severe Disabilities: Humans are social beings who need to live in communities. According to Ratchanee Sansoen et al. (2013), individuals with disabilities should live within communities. In Bangkok, most communities are characterized by a high degree of social separation, such as gated communities, condominiums, and apartments. In such settings, people are less likely to know each other, form bonds, or engage in community activities. However, emotional and psychological connections among community members can enhance the community’s capacity for mutual support and involvement in various activities. Ratchanee Sansoen et al. (2013) found that in more densely populated and traditional communities, there is greater support for individuals with disabilities, including assistance with physical care such as medication, diapers, wheelchairs, and other necessary equipment. 3) Private Sector Care for Individuals with Severe Disabilities:

Some families may not be able to care for individuals with severe disabilities due to work commitments or advanced age, and therefore choose to use private care services, such as nursing homes, nursing care facilities, or disability care centers. 4) Family-Based Care for Individuals with Severe Disabilities: Despite the high stress and demands of living in Bangkok, where families face high living costs and time pressures, families make significant efforts to adjust and manage their time to provide care for individuals with severe disabilities. This aligns with Tunyaluk Roongsangjun’s (2020) study, which identified two types of care for individuals with disabilities: 1) Institutional Care, where care is provided by the state with clear procedures and processes, and 2) Deinstitutional Care, which focuses on family-based and community-based models. These models are flexible and adaptable based on economic, social, and familial factors, leading to varying needs, problems, and limitations for each family.

Additionally, it was found that individuals with severe disabilities often face an initial inability to accept and adapt to their disability. This is particularly true for those who acquire their disability later in life, such as those who were previously able to move and live normally but later experience accidents or illnesses like strokes or brain hemorrhages. These individuals often encounter significant challenges in the early stages and may exhibit denial of their disability. This finding aligns with Kamlapan Panpeung’s (2008) classification of disability identity, where the first type involves denial of the disability, with individuals saying, "I am not disabled," as they do not wish to be associated with the disability group or to be labeled as "disabled." They may view disability as a symbol of depression, pity, undesirability, and incapacity, preferring to be referred to as "ill" or by other terms. Being labeled as "ill" is perceived as more desirable because it suggests the possibility of recovery and does not include them in the disabled group. Denial or inability to adapt to the disability can lead to delays in accepting physical, emotional, and welfare care, resulting in inadequate and delayed care. This pattern is more common among individuals who acquire disabilities later in life. In contrast, individuals born with disabilities often experience the second type of disability identity, characterized by feelings of monotony, lack of enthusiasm, and a sense of merely "getting by," with diminished life goals. Therefore, mental health care is crucial and should be prioritized, as acceptance and adaptation to disability, along with psychological resilience, significantly affect motivation, self-care, and physical activity. This is consistent with Silverman et al. (2015), who found that a strong mental state and positive emotional interactions (Wang et al., 2023, pp. 5-12) help individuals with disabilities lead a continuous and engaged life. Furthermore, individuals with disabilities develop a better understanding of their ability to face problems, manage situations, and control their emotions (Hassanein et al., 2021), which can lead to improved physical and disability outcomes. Another crucial factor is the attitude, acceptance, and understanding of the disability by caregivers, family members, friends, the community, and society, which significantly impacts the feelings of individuals with disabilities.

5.2.2 Guidelines for Caring for Individuals with Severe Disabilities by Their Families

5.2.2.1 Guidelines for Physical Care of Individuals with Severe Disabilities

Individuals with severe disabilities often have limited or no ability to assist themselves or perform daily activities. Some may be unable to manage bodily functions independently or require a specialized diet, such as blended food. According to the Disability Quality of Life Promotion and Development Act (2007), the levels of assistance for individuals with severe disabilities are classified as follows: Level 1: Individuals who cannot perform daily activities independently and require significant assistance from others. Level 2: Individuals who can perform some daily activities but need considerable help from others. They may need guidance, supervision, or assistive devices but cannot go out independently to pursue education, employment, or social activities, even in a supportive environment. Caregivers, typically close family members familiar with and related to the individual, must provide comprehensive physical care. This includes understanding the nature, capacity, and limitations of the individual's disability. Providing necessary assistive devices can enhance the quality of care and support the individual's daily living activities.

5.2.2.2 Guidelines for Social Care of Individuals with Severe Disabilities

Social care for individuals with severe disabilities is another crucial aspect that impacts their treatment and condition and should not be overlooked. This involves providing opportunities for individuals with disabilities to meet people, such as family members, friends, and acquaintances, and to participate in community and social activities, such as New Year celebrations, Songkran, and significant religious events. Additionally, engaging in activities like traveling to different places, such as beaches or temples, is important. Individuals with disabilities have a need for happiness and a sense of identity, and social interactions and outings can help ensure they do not remain isolated at home. Research by Rapeepan Kumhom and Wannawadee Poolphoksin (2019) found that emphasizing cultural participation, recreational activities, relaxation, and sports, in line with the United Nations Convention on the Rights of Persons with Disabilities and the needs of individuals with disabilities, contributes to a better quality of life. However, some families of individuals with disabilities face financial difficulties, making it challenging to afford participation in activities or travel due to high costs and various inconveniences. This is consistent with findings by Phinyo Prakobphon (2016) in the study on the development and enhancement of the quality of life for individuals with disabilities, which revealed that poverty limits opportunities for skill development and continuous rehabilitation, leading to additional problems such as limited access to information, participation, and discrimination. Obstacles to promoting social care, affecting the ability to engage in activities and travel, were identified by Kittiwat Chatrisriphop and Faculty of Law, Ubon Ratchathani University. (2015). These obstacles include difficulties in traveling, lack of accessibility, communication barriers, and financial issues such as the inability to afford transportation and food. Therefore, providing support or travel welfare, such as free or discounted transportation services and financial assistance, is essential for individuals with disabilities.

5.2.2.3 Guidelines for Welfare Rights of Individuals with Severe Disabilities

Individuals with disabilities must receive equal, fair, and dignified care in terms of their rights and welfare, according to human rights principles that state all people are entitled to equal rights (United Nations, 2007). Therefore, people with disabilities should have the same rights as everyone else, and they should have equal access to services and facilities that meet their needs. However, studies on the welfare rights for the care of individuals with severe disabilities reveal that some individuals are unaware of the rights and benefits they are entitled to as Thai citizens. This lack of awareness is often due to disinterest in seeking knowledge, not being informed, and spending most of their time working. This is consistent with findings from Phakchon Matcha (2013) on the development of service delivery and the promotion and enhancement of the quality of life for people with disabilities. It was observed that while people with disabilities and their families have a good understanding of their rights related to social services and disability benefits due to extensive media coverage, they often lack accurate knowledge about education rights. Furthermore, there is limited understanding of other essential welfare services needed for daily living, employment, or business activities, leading to difficulties in accessing these rights. Regarding benefits from private sectors or non-governmental organizations (NGOs), individuals with disabilities often lack awareness of their rights and thus fail to access these services or are not recognized as target beneficiaries. Therefore, welfare rights for individuals with disabilities need to be widely publicized through various channels to ensure that both individuals with disabilities and their families are informed. Services should be provided comprehensively and equitably, delivered promptly, and tailored to meet the specific needs, necessities, and cost of living of individuals with disabilities.

5.2.2.4 Support Systems for the Care of Individuals with Severe Disabilities

Family caregivers of individuals with severe disabilities cannot manage care on their own. Some families may be unprepared to provide care due to various factors such as a lack of knowledge, essential caregiving equipment, financial issues from leaving work, and expenses related to the disability. Therefore, a support system is necessary to assist families in providing comprehensive care in areas including physical, emotional, social, and welfare rights. Support systems can be derived from social networks, as identified by Thanirat Phongphaew (2014), including communities, social organizations, government and private organizations, civil society, and social support resources. Additionally, close support networks identified by Kanyawee Promphan et al. (2013) include spouses, children, friends, and relatives. These support systems are crucial to ensuring that the needs and well-being of individuals with disabilities are met appropriately and to facilitate improvements in their physical, emotional, and social conditions, thereby enhancing their quality of life. Similar findings by Jinda Rattanakul et al. (2013) show that individuals with disabilities need support with daily activities and mobility. Caregivers require assistance and knowledge from various organizations within the community. As caregivers may lack knowledge about the condition and daily living skills, support from other family members, friends, or community members is essential for rotating caregiving responsibilities and ensuring comprehensive care.

Temporary Respite Care and Support Systems The implementation of a respite care system is crucial for family caregivers who need breaks for rest, to attend to other responsibilities, or when they are ill. This system can be formal or informal and can involve services either within or outside the home (European Union Agency for Fundamental Rights, 2017). It is an essential component in supporting family caregivers of individuals with severe disabilities. According to the study by Kwanpracha Chiangchaisakulthai et al. (2022), a respite care system should be established. This system would offer temporary care for individuals with disabilities, managed by members of the same association. This setup allows individuals with disabilities to stay with peers and familiar caregivers around the clock, while their primary caregivers can take time off for other tasks or rest. Such arrangements help reduce caregiver stress, pressure, and negative feelings associated with long-term, continuous caregiving. Family support services are also necessary to address economic challenges and time management issues related to caregiving. These services can facilitate a better quality of life for families and individuals with disabilities by improving access to essential rehabilitation services, supporting family income, and providing affordable or free internet access. These resources help families and individuals with disabilities access useful information and skill-building opportunities. Moreover, the development of foster care systems, or "moral families," is needed. This involves providing care by others who temporarily take over the caregiving role when the primary family caregivers are unable to do so. Research by

Rapeepan Kumhom and Tunyaluk Roongsangjun (2019) supports this approach, noting that such systems can reduce the need to place individuals with disabilities in crowded and potentially less comprehensive care facilities.

Additionally, the development of telemedicine systems is essential. Telemedicine allows individuals with disabilities to access medical services, receive diagnoses, and consult with doctors without needing to travel to hospitals. This approach addresses the difficulties and high costs associated with travel, especially since public transportation may not be suitable for those with severe disabilities. Many individuals with disabilities and their families rely on expensive options such as taxis, private ambulances, or vehicles provided by charities. Telemedicine can significantly reduce these travel-related challenges and costs. However, issues may arise with conducting scientific or medical tests, such as blood tests, X-rays, ultrasounds, and biopsies. These challenges might be mitigated by having public health centers assist with testing and results recording, or by having family members bring test results to doctors on behalf of the individuals with disabilities.

5.2.2.5 Assessing the Problems, Needs, and Requirements of Individuals with Severe Disabilities and Their Families

To effectively care for individuals with severe disabilities, it is crucial to assess their problems, needs, and requirements by directly listening to the voices of the disabled individuals and their families. This feedback should be used to improve and develop various practices, laws, services, and benefits to align with the real issues and needs of these individuals and their families. Since these needs are dynamic and vary from person to person, a bottom-up development approach is essential. According to Amorn Raksasat (2003), development management should emphasize equality for all groups and involve the people directly affected by the development. Sustainable development should originate from the community or those directly impacted, rather than relying on top-down approaches. In addition to the family-based care for individuals with severe disabilities previously discussed, it is essential to focus on updating laws, regulations, and policies related to disabilities to ensure they are modern and responsive to the evolving challenges of disability care. This will facilitate rigorous enforcement and align with the innovative care approaches proposed by Jirawat Thewawatpakorn et al. (2021). Improving legal frameworks that support the care and protection of individuals with disabilities will strengthen and enhance the quality of care. This approach must also comply with the Universal Declaration of Human Rights by the United Nations (2007), which asserts that everyone has the right to an adequate standard of living for health and well-being, including food, clothing, housing, medical care, and necessary social services. It should also include measures to penalize those who exploit, abuse, or harm individuals with disabilities, protecting these vulnerable individuals from harm and ensuring their safety.

5.2.3 Model of Family Care for Individuals with Severe Disabilities

Based on in-depth interviews with key informants, a comprehensive model of care for individuals with severe disabilities has been developed. This model aims to address the entire lifespan of the individual, from the onset of the disability through to the end of life. The model emphasizes a holistic approach to care, which means addressing all aspects of the individual’s needs. The holistic care model for individuals with severe disabilities involves understanding the nature of the disability and its limitations. Individuals with severe disabilities often have very limited or no ability to assist themselves, thus requiring comprehensive support in the following areas: 1) Physical well-being 2) Emotional and psychological health 3) Social relationships 4) Environmental factors This approach is consistent with studies on quality of life for individuals with disabilities by Thapthim Siwilai et al. (2022); Ratchanee Sansoen et al. (2013). Furthermore, Ratchanee Sansoen et al. (2013) also found that spiritual care is crucial. This aspect involves helping individuals find purpose and meet their needs for meaning in life, including desires, beliefs, love, forgiveness, and religious practices. Additionally, caregivers need to be educated on various aspects of daily care, such as routine activities, wound care, preparing blended food (for individuals who require feeding tubes), physical therapy, and safe lifting and transferring techniques. Care also needs to cover the rights and welfare benefits of individuals with disabilities to ensure equal and dignified treatment (United Nations, 2015). Thus, family care for individuals with severe disabilities should be a holistic approach, supported by a strong and resilient family unit. This family should interact positively, be self-sufficient, adaptable, capable of providing care, and maintain high standards of family strength (Office of Women and Family Affairs, 2011). A strong family can ensure sustainable care for the individual with disabilities. As evidenced by the study of factors influencing the quality of life for individuals with disabilities by Porntip Tanthong et al. (2019), a sustainable disability model through holistic care will provide comprehensive and appropriate support, preventing excessive focus on or neglect of any particular aspect of care. Besides holistic care within a strong family framework, it is essential to assess and monitor care to improve its quality continually. Issues that arise should be addressed. The state, as a legitimate authority with legal power, has the responsibility to manage and enhance care to ensure better support for individuals with disabilities. Thus, the model for family care of individuals with severe disabilities is a holistic model as illustrated in Figure 5.1.

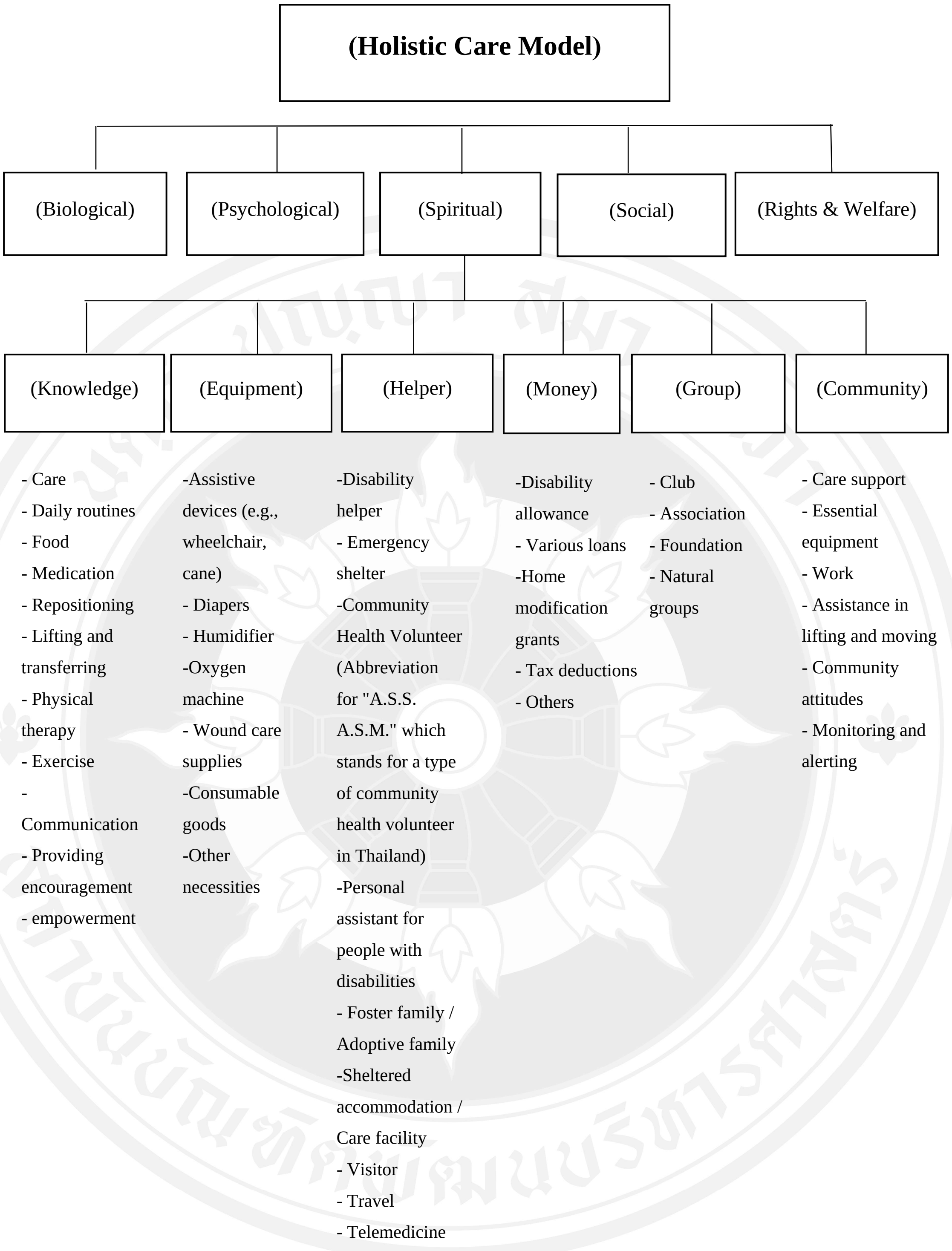


Figure 5.1 Model for Family-Based Care of Individuals with Severe Disabilities

Based on the above illustration, the model for caring for severely disabled individuals by their families consists of five dimensions: Biological, Psychological, Spiritual, Social, and Rights & Welfare. It includes six components of care:

1) Knowledge: Providing knowledge to disabled individuals and their families about daily care routines, wound care, medication, safe transfer techniques, physical therapy, wheelchair skills, use of assistive devices, exercise, effective communication, encouragement, and empowerment.

2) Equipment: Necessary equipment for the disabled individual's daily life, including beds, wheelchairs, diapers, canes, oxygen machines, ventilators, suction devices, wound care supplies, and consumables.

3) Caregivers: Individuals who assist in caregiving when the primary family caregiver needs rest, has errands, or is ill, such as public health volunteers, village health volunteers (VHV), social and human security development volunteers (SHS), personal assistants, emergency or crisis care homes, protective homes, foster families, adoptive families, visitors, travel companions, and telemedicine consultations.

4) Money: Financial support for disabled individuals and their families, including disability benefits, business loans, home modifications, tax exemptions, and tax deductions.

5) Groups: Assistance from organized groups such as foundations, associations, and disability clubs, as well as natural groups like relatives, friends, neighbors, and acquaintances.

6) Community: Community support includes temporary care for the disabled when requested, provision of necessary equipment, job opportunities such as craft work or sewing, assistance with lifting and transporting the disabled to hospitals or within the home, community attitudes towards disabled individuals, and monitoring and alerting for emergencies.

Thus, the study finds that caring for severely disabled individuals requires a holistic approach encompassing all dimensions. Existing knowledge from previous research includes Biological, Psychological, and Rights & Welfare dimensions. New findings from this study include the Spiritual dimension, which involves comprehensive care that extends to finding purpose and addressing the disabled individual's needs related to values or meaning in their life, including desires, beliefs, love, forgiveness, and religious rituals. Additionally, the Social dimension involves allowing disabled individuals to meet and interact with relatives, friends, and others, and to participate in activities and travel according to their abilities, which brings joy to the disabled individual. Knowing that travel is possible if their health improves can motivate disabled individuals to take better care of themselves, engage in physical therapy, and focus on recovery, ultimately benefiting both the disabled individuals and their caregivers.

5.3 Recommendations

5.3.1 Policy Recommendations

1) Develop Temporary Care Systems: There should be a development of temporary care systems or substitute caregivers to allow primary caregivers time to rest. This can help reduce stress, boredom, depression, and other pressures that may lead to neglect or abuse of the disabled individual. Temporary caregivers should be trained with knowledge, skills, and expertise specific to caring for severely disabled individuals. This system could be managed by government agencies, local authorities, or community organizations.

2) Establish Supportive Residences: There should be facilities or homes to accommodate cases where the primary caregiver is elderly or deceased and can no longer care for the disabled individual. These should not be institutionalized care homes but should be situated within or near the disabled person's community. Local communities and local authorities should manage these facilities, employing community members as caregivers, with government funding or support for foster or adoptive families to take care of the disabled individual.

3) Implement Legal Measures: There should be measures or laws to seriously and consistently penalize those who commit violence or exploit disabled individuals.

5.3.2 Research Recommendations

1) Study the Application of the Model in Other Economic Cities: There should be studies on applying the model for caring for severely disabled individuals by families in other economically similar cities to Bangkok, such as Chiang Mai, Phuket, and Chonburi, or in urban areas of other Asian countries like Singapore, the Philippines, and Japan.

2) Examine the Role of Various Groups: Research should be conducted on the roles of organizations such as foundations, associations, and disability clubs in supporting family caregiving for disabled individuals. These groups serve as sources of knowledge and provide flexible, accessible, and prompt support for family caregivers, with minimal procedural steps.

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APPENDIX

Questions for In-Depth Interviews with People with Severe Disabilities

1. What is the cause of your disability?

2. Which daily activities are you able to perform?

3. What is the relationship between you and your caregiver, and what kind of care do they provide for you?

4. Where do you seek information and knowledge about caring for people with disabilities in terms of physical, emotional, and mental care, as well as rights and benefits?

5. How do you currently care for people with physical disabilities, emotional and mental well-being, and their rights and benefits? What do you think future care will look like?

6. What problems do you encounter in the daily lives of people with disabilities and in their caregiving?

7. What are your expectations or needs for the care of people with disabilities or assistance from other agencies?

Questions for In-Depth Interviews with Families Caring for People with Severe Disabilities

1. What is the cause of the disability of the person you are caring for?
2. Which daily activities is the person you are caring for able to perform?
3. What is your relationship with the person you are caring for, and what aspects of their care do you provide?
4. Where do you seek information and knowledge about caring for people with disabilities in terms of physical, emotional, and mental care, as well as rights and benefits?
5. How do you currently care for the physical, emotional, and mental well-being of the person with a disability, as well as their rights and benefits? What do you think the future of this care will look like?
6. What problems do you encounter in the daily life of the person with a disability and in the caregiving process?
7. What are your expectations or needs for the care of people with disabilities or for assistance from other agencies?

Questions for In-Depth Interviews with Academics or Experts in Disability

1. What are your views on disability, its causes, the ability of individuals to self-care, and the role of caregivers?
2. What do you think should be the approach for families to care for individuals with severe disabilities?
3. Where do you think people with disabilities and their families can find information or knowledge about caring for individuals with disabilities, including physical, emotional, and mental aspects, as well as rights and benefits?
4. What are your views on the current and future methods or approaches for caring for individuals with physical disabilities, emotional and mental health needs, and their rights and benefits?
5. What are the challenges faced in the daily lives of individuals with disabilities and in their care by caregivers?
6. What are your expectations or needs regarding the care of individuals with disabilities or assistance from other agencies?
7. How do you think rules, regulations, and policies regarding disabilities should be improved to ensure more effective care for individuals with disabilities?

BIOGRAPHY

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