VELNORA PUBLISHERS
PUBLISHING KNOWLEDGE INSPIRE WORLD

International Journal of Global Psychology
IJOGP

Mindfulness-Based Practices for Learners with Intellectual Disabilities: A Holistic Educational Perspective - A Narrative Review

Solanki T*

Assistant Professor Shri P. K. Mehta College of Special Education, India

***Corresponding author:** Toral Solanki, Assistant Professor (Special Education – Intellectual Disability) Shri P. K. Mehta College of Special Education, Palanpur, Gujarat, India, Tel: +91 9054712873; Email ID: toralsolanki8@gmail.com

Review Article

Volume 1 Issue 1

Received Date: October 29, 2026

Published Date: November 07, 2026

Abstract

Mindfulness is commonly described as the intentional regulation of attention toward present-moment experiences with an attitude of openness and acceptance. This narrative review considers the potential relevance of mindfulness-based interventions and mindfulness-informed educational practices for learners with intellectual disabilities (ID). Literature was identified through Google Scholar, as reported for the review, with attention to publications from 2020 to 2026; foundational theoretical and earlier review papers were retained where necessary. The available evidence includes small studies involving adults with ID, research on staff interventions, and studies involving caregivers. Findings are promising in selected areas such as well-being, quality of life, and staff–participant interactions, but the evidence is preliminary and heterogeneous. Much of it does not directly concern school-aged learners with ID, and therefore cannot be generalized to this population without caution. The paper synthesizes the evidence by outcome area and discusses adaptations involving short sessions, concrete language, visual supports, communication systems, sensory choice, and movement-based options. It proposes an assess–adapt–implement–monitor–adjust framework and illustrates how optional mindfulness-related objectives may be written into Individualized Education Programmes (IEPs) without displacing academic, communication, or functional goals. Ethical safeguards, teacher competence, family partnership, cultural responsiveness, and research priorities are also discussed. Mindfulness is presented as a complementary, voluntary educational support, not as a treatment for ID or a replacement for evidence-based educational, behavioural, psychological, or medical services.

Keywords: Mindfulness, Intellectual Disabilities, Narrative Review, Inclusive Education, Emotional Regulation, Mental Well-being, Special Education

Introduction

Education extends beyond academic achievement and includes emotional, social, physical, psychological, communication, and adaptive development. For learners with intellectual disabilities (ID), meaningful educational outcomes include participation, autonomy, communication, social relationships, functional independence, and quality of life alongside academic learning. Intellectual disability involves significant limitations in intellectual functioning and adaptive behaviour originating during the developmental period; adaptive behaviour includes conceptual, social, and practical skills (American Association on Intellectual and Developmental Disabilities [1]. Educational planning should

therefore recognize individual strengths and support needs rather than define learners only by limitations.

People with ID may encounter barriers to expressing distress, accessing mental-health services, and participating in social and educational environments. The World Health Organization (2) notes that people with disabilities experience health inequalities associated with barriers, stigma, discrimination, and unequal access to services. In addition, mental-health difficulties may be overlooked when changes in behaviour or emotional expression are attributed automatically to the disability itself. This problem, often discussed as diagnostic overshadowing, can delay appropriate assessment and support.

Mindfulness is one possible complementary approach to well-being. In psychological literature, it is associated with intentional attention to present-moment experiences and an orientation of openness and acceptance [3]. In educational settings, mindfulness-informed activities may include noticing breathing, listening to a sound, identifying an emotion, or attending to a tactile object. These brief classroom practices should not be equated with structured clinical mindfulness-based interventions (MBIs), such as formal multi-session programmes. Evidence from clinical programmes cannot automatically be transferred to short classroom activities or to learners with different levels of support needs.

The present review has three aims: (a) to summarize available evidence on mindfulness-related practices involving people with ID and relevant caregivers or staff; (b) to identify adaptations and safeguards required for educational use; and (c) to propose a practical framework for considering mindfulness as an optional complement to individualized special education. The guiding questions are: What outcomes have been reported in the available literature? What adaptations are necessary for learners with diverse communication, cognitive, and sensory profiles? What ethical and implementation conditions should guide classroom use?

Conceptual Understanding of Mindfulness

Bishop et al. [3] proposed a two-component operational model of mindfulness: self-regulation of attention toward immediate experience and an orientation characterized by curiosity, openness, and acceptance. Mindfulness may be discussed as a state, a dispositional tendency, a skill developed through practice, or a structured intervention. These meanings should be distinguished when interpreting research. A participant's momentary attention during a classroom activity is not equivalent to completing a standardized MBI.

Kabat Zinn J [4] described mindfulness-based interventions in clinical and health contexts as practices involving intentional awareness. In adapted educational activities, the underlying principle can be translated into concrete prompts such as "notice your breathing," "listen until the sound ends," or "feel the texture of this object." Such activities may support attention and awareness, but their effects should be measured rather than assumed. Mindfulness is not simply relaxation, quiet sitting, obedience, or compliance training. It should not be used to suppress a learner's distress signals or to make a learner appear more manageable. It is also not a substitute for functional behaviour assessment, communication support, positive behaviour support, psychotherapy, psychiatric care, or medical treatment.

Mindfulness has historical associations with Buddhist contemplative traditions, while contemporary clinical programmes often use secular language and procedures. In Indian educational settings, cultural adaptation should be respectful and non-coercive. Educators may explain activities through familiar ideas of attention, awareness, breathing, and noticing, without requiring religious participation or presenting one tradition as universally appropriate. Learners and families should be able to decline activities that conflict with their beliefs or preferences.

Intellectual Disability and Mental Well-being

Learners with ID are heterogeneous in intellectual functioning, adaptive skills, communication, sensory processing, physical abilities, and support requirements. Mental well-being is influenced by individual experiences and environmental conditions, including predictable routines, accessible communication, relationships, safety, opportunities for choice, and participation. Some learners may communicate anxiety, pain, frustration, or sensory discomfort through behaviour rather than spoken language. Behaviour that challenges should not automatically be interpreted as mental illness or as a reason to impose mindfulness. It may signal pain, unmet needs, communication barriers, an inaccessible task, trauma, sensory overload, or an environmental mismatch. Assessment should consider medical, psychological, communication, and contextual factors. Diagnostic overshadowing is a particular concern: symptoms of a mental-health condition may be incorrectly attributed to ID, while behaviours associated with ID may be misread as psychiatric symptoms. Mindfulness must never delay a suitable assessment or referral. Accordingly, mindfulness-related activities should be considered only as one optional element within a wider, person-centred support plan. The learner's communication, comfort, assent, and preferences should guide implementation.

Copyright© Solanki T.

Review Method

This paper is presented as a narrative review rather than a systematic review or meta-analysis. Google Scholar was identified as the literature-search source for the review, and the intended publication focus was 2020–2026. Foundational conceptual publications and earlier reviews were retained when needed to explain the construct and the development of the field. Search concepts relevant to the topic included combinations of the terms "mindfulness," "mindfulness-based intervention," "intellectual disability," "intellectual and developmental disabilities," "mental well-being," "special education," "caregiver," "staff," and "inclusive education." These are topic concepts used to organize the review; they should not be interpreted as a verbatim record of historical Boolean search strings. The exact historical search date, complete search strings, number of records retrieved, number screened, and number included were not retained in the materials available for this revision. Consequently, a PRISMA flow diagram, a reproducible screening count, and a formal risk-of-bias assessment cannot be reported honestly. Studies and reviews were considered relevant when they addressed mindfulness or mindfulness-informed practice in people with ID or developmental disabilities, or in staff and caregivers supporting this population. Research involving staff or parents was treated as indirect evidence and was not presented as proof of effectiveness for learners themselves. Foundational theoretical work was used for definitions.

Studies unrelated to ID or developmental disability, and material without a clear connection to mindfulness or the educational question, were not used to support population-specific conclusions. Findings were organized thematically by participant group, outcome, and implementation relevance. Because the included literature differs in design, sample, intervention, and outcome measurement, findings were not statistically pooled. No formal quality-appraisal instrument was applied. Instead, the synthesis notes study design, sample size where reported, directness to school-aged learners, and limitations. The absence of a documented search log and formal appraisal is a limitation of this narrative review and should be addressed in future updates through a prospectively recorded search and screening procedure.

Evidence from Existing Literature: Critical Synthesis

The available literature is small and varied. It includes studies of adults with ID, interventions for staff, and programmes for caregivers. These groups and outcomes should be distinguished because improvements in staff well-being or caregiver stress do not demonstrate direct effects on learners with ID.

Studies involving adults with intellectual disabilities

Croom et al. [5] explored the experiences of nine adults with ID attending an eight-week mindfulness-based group intervention. Participants described the group as meaningful and enjoyable, with opportunities for engagement, social interaction, and friendship. The qualitative focus provides useful information about acceptability and lived experience, but the small sample and absence of a large controlled comparison limit conclusions about effectiveness. Lake and MacHale [6] reported a pilot eight-week Mindfulness-Based Stress Reduction group involving seven adults with mild ID. The study reported improvement in overall well-being; self-esteem also improved, although the change was not statistically significant. As a small pilot, the study supports feasibility and further investigation rather than a definitive efficacy claim.

Power et al. [7] evaluated a six-session Coping Well Group across six cohorts involving 25 adults with ID. The authors reported a small but statistically significant improvement in quality of life ($d = 0.46$, $p = .022$). The findings are encouraging, but the sample and programme context limit generalization, and some participants continued to require individual therapy. Group-based mindfulness should therefore not be treated as a replacement for individualized support. Gandía-Abellán et al. [8] reported a pilot study of the MindfulTEA programme involving adults with autism spectrum disorder and intellectual disability. This work is relevant to adapted practice, but it concerns a specific participant group and pilot design. It should not be generalized to all learners with ID or treated as evidence for school-based programmes without further study.

Evidence involving staff and caregivers

Sturgeon [9] systematically reviewed mindfulness interventions for staff supporting people with ID. Across nine studies, reported outcomes included potentially more positive staff interactions and reductions in some restrictive practices or challenging interactions. The review also identified limitations in the underlying evidence, including small samples and methodological weaknesses. These findings suggest that staff-focused programmes may be relevant to service quality, but they are indirect evidence for learner outcomes. Ó Donnchadha [10] reviewed mindfulness-based interventions for caregivers of people with intellectual or developmental disabilities. The review reported some short-term benefits for caregiver distress, while findings were not uniform across outcomes and methodological limitations remained. Caregiver well-being is important in a holistic support system, but caregiver outcomes must be kept analytically separate from direct learner outcomes.

Copyright© Solanki T.

Yang et al. [11] conducted a systematic review and meta-analysis of mindfulness-based interventions for parents of children with intellectual or developmental disabilities. The review included 15 studies and 1,124 parents and reported improvements in several parent mental-health outcomes and parent–child relationship measures. This is relevant to family support, but it does not establish that mindfulness directly improves mental health or learning outcomes in children with ID.

Evidence summary

Study	Participants / design	Intervention or focus	Reported findings	Key limitation / relevance
Croom, et al. (5)	9 adults with ID; qualitative study	8-week mindfulness group	Acceptability, engagement, social connection	Small sample; experience-focused, not definitive efficacy evidence
Lake & MacHale (6)	7 adults with mild ID; pilot study	8-week MBSR group	Improved overall well-being; self-esteem change not statistically significant	Very small pilot; adult sample
Power, et al. (7)	25 adults across 6 cohorts	6-session Coping Well Group	Small significant quality-of-life improvement (d = 0.46, p = .022)	Limited sample; some participants still needed individual therapy
Gandía-Abellán, et al. (8)	Adults with autism and ID; pilot study	MindfulTEA programme	Explored adapted mindfulness feasibility	Specific group and pilot design; cautious generalization
Sturgeon (9)	9 staff-intervention studies; systematic review	Mindfulness for staff supporting people with ID	Potentially improved interactions and some care outcomes	Indirect learner evidence; methodological limitations
Yang, et al. (11)	15 studies; 1,124 parents; systematic review/meta-analysis	Mindfulness for parents	Improvements in selected parent outcomes	Parent outcomes, not direct child outcomes

Table 1: A Systematic Review and Meta-Analysis of Mindfulness-Based Interventions for Parents of Children with Intellectual or Developmental Disabilities.

Overall, the most direct evidence for people with ID is concentrated in small adult studies. The literature is more developed for staff and caregiver outcomes than for school-aged learners. Evidence for attention, academic performance, and classroom learning outcomes among children with ID remains insufficient in the studies summarized here. Thus, classroom activities discussed below are proposed as educationally plausible adaptations and should not be described as interventions with established efficacy for all learners.

Rationale and Potential Educational Relevance

Attention and task transitions

Short listening or breathing activities may provide a predictable transition into a learning task. However, the reviewed ID-specific studies do not establish a reliable effect on academic attention in school-aged learners. Attention should be measured through observable, individualized indicators rather than assumed.

Emotional awareness and communication

Emotion cards, facial-expression visuals, and supported choice may provide opportunities for learners to communicate how they feel. These strategies are compatible with accessible communication practice, but direct controlled evidence that mindfulness itself improves emotion recognition in learners with ID remains limited.

Coping and well-being

Small adult studies report encouraging well-being or quality-of-life outcomes. These findings support further study of adapted coping programmes, while age, context,

Copyright© Solanki T.

sample size, and programme differences limit transfer to school-aged learners.

Social participation

Group programmes may create opportunities for shared activity and social connection, as suggested by participant experiences reported by Croom et al. (5). It remains unclear whether such benefits result from mindfulness specifically, group participation, facilitator attention, or a combination of factors.

Staff and family well-being

Staff and caregiver interventions may indirectly support a more responsive environment. Their value should be evaluated separately from learner outcomes, and participation by staff or parents should not be treated as a substitute for direct services to the learner.

Adaptation Framework for Educational Use

The following assess–adapt–implement–monitor–adjust framework is proposed as a practical decision aid. It is an educational framework derived from the review's synthesis, not a validated clinical protocol.

1. **Assess:** Identify the learner's strengths, communication method, sensory preferences, mobility, support needs, possible trauma-related sensitivities, and the purpose of the proposed activity. Consider whether distress may indicate pain, unmet need, or an inaccessible environment.
2. **Adapt:** Select a brief, concrete activity; use visual or object cues, modelling, repetition, augmentative and alternative communication (AAC), and movement options. Avoid compulsory eye closure, silence, touch, or controlled breathing.
3. **Implement:** Explain and demonstrate the activity, offer meaningful choice, allow the learner to observe or decline, and keep participation voluntary. Begin with a very short duration and a familiar routine.
4. **Monitor:** Record observable indicators such as voluntary engagement, learner choice, communication of comfort or discomfort, duration tolerated, use of a chosen coping strategy, and any signs of distress. Do not equate stillness or obedience with well-being.
5. **Adjust or Stop:** Modify, pause, or discontinue the activity when the learner shows discomfort, avoidance, increased distress, or no meaningful benefit. Consult the family and relevant professionals where appropriate.

Activity	Adapted procedure	Purpose and safeguard
Mindful breathing	Invite the learner to notice natural breathing for a short period. Use a visual card or hand-on-abdomen cue only if comfortable. Do not require deep or controlled breathing.	Attention and body awareness; stop if breathing focus causes discomfort.
Five-senses noticing	Offer a choice of safe objects, sounds, colours, or textures and invite the learner to notice one feature. Avoid strong fragrances or tasting activities where allergies, swallowing risks, or dietary restrictions may apply.	Sensory attention and communication; adapt to sensory preferences.
Mindful movement	Use gentle stretching, slow walking, hand movements, or seated movement according to mobility and physical needs.	Body awareness and participation; follow relevant physical or therapy guidance.
Mindful listening	Play a familiar, comfortable sound at a suitable volume and invite the learner to signal when it stops. The learner may choose not to participate.	Auditory attention; avoid startling or aversive sounds.
Emotional check-in	Offer emotion pictures, symbols, objects, AAC, or gesture choices. Accept "not sure," no response, or a preference not to share.	Emotional communication; never require disclosure.

Copyright© Solanki T.

Calm choice area	Provide an optional area with familiar sensory materials, visual choices, and quiet activities. It must not be used as isolation or punishment.	Choice and self-regulation; maintain supervision and access to communication.

Table 2: Suggested Mindfulness-Informed Activities.

Differentiation is essential. Learners who use AAC or nonverbal communication may indicate preferences through symbols, eye gaze, gestures, switches, or partner-assisted scanning. Learners with profound and multiple disabilities may participate through brief, familiar sensory or movement experiences only when these are comfortable and approved within their support plans. For learners with greater independence, reflective language or longer activities may be appropriate if they choose. The aim is access and agency, not a uniform duration or performance standard.

Integration with Individualized Education Programmes

Mindfulness-related objectives may be included in an IEP only when they address an identified learner need and do not displace core academic, communication, self-care, mobility, vocational, or functional goals. Objectives should be specific, measurable, achievable, relevant, and time-bound (SMART), with clear baseline information, prompt levels, contexts, and review dates.

Area	Illustrative SMART-style objective	Monitoring indicator
Emotion communication	Within 12 weeks, when offered an accessible emotion display, the learner will select or communicate one of at least three emotion options in 4 of 5 naturally occurring check-ins, with the agreed level of prompting.	Frequency and prompt level; learner may choose not to respond.
Choice of coping strategy	Within 10 weeks, when the learner indicates discomfort and a calming option is appropriate, the learner will choose or reject one offered support option in 4 of 5 observed opportunities.	Choice, rejection, communication mode, and context.
Voluntary participation	Over 8 weeks, the learner will voluntarily engage in a selected listening or sensory-awareness activity for an individually agreed short period in 3 of 5 opportunities.	Voluntary engagement, duration, comfort signals.

Table 3: Objectives should be specific, measurable, achievable, relevant, and time-bound (SMART).

These are examples, not standard targets. The IEP team should establish an individual baseline, obtain learner and family input, select meaningful outcomes, and review feasibility. Monitoring should include the learner's assent, choice, comfort, communication, and functional use of strategies. Administrative workload should be considered; simple recording tools are preferable to burdensome documentation.

Role of Special Educators and Professional Competence

Special educators can identify whether an activity is relevant to an educational goal, adapt materials, model the activity, offer choices, and monitor learner responses. They should not diagnose mental-health conditions or present classroom mindfulness as psychotherapy. If significant anxiety, depression, trauma-related concerns, self-injury, or other clinical concerns are suspected, the learner should be referred through appropriate professional pathways. Before facilitating structured activities, educators should receive orientation in the basic principles and limits of mindfulness, disability-responsive communication, sensory accessibility, trauma-informed practice, consent and assent, safeguarding, and referral procedures. More intensive or clinical MBIs should be delivered only by appropriately trained and supervised practitioners within their professional scope. Institutions should define procedures for supervision, incident reporting, and review of adverse responses. Fidelity should be understood as consistent delivery of the intended safe and accessible elements, not rigidly requiring every learner to perform the same action. Educators should document the activity offered, adaptations made, learner choice, and observable response.

Copyright© Solanki T.

Role of Parents and Families

Families can help identify activities that are familiar, acceptable, culturally meaningful, and comfortable for the learner. Home–school communication may support consistency, but families should not be expected to deliver formal therapeutic programmes without training. Simple optional routines, such as noticing a familiar sound or choosing a calming activity, may be shared when the learner enjoys them. In the Indian context, family structures, languages, beliefs about disability, stigma, caregiver burden, and the role of extended family may influence whether and how activities are accepted. Educators should avoid assumptions about family beliefs and should invite families to explain preferences in their own terms. Materials should be available in the learner's preferred language and should not require religious participation. Caregiver well-being deserves attention in its own right, as reflected in caregiver-focused literature, but it should not be conflated with direct learner outcomes.

NEP 2020 and Holistic Education

The National Education Policy 2020 emphasizes holistic development, learner-centred education, inclusion, flexibility, multidisciplinary learning, and the development of cognitive, social, emotional, and physical capacities (12). These broad priorities provide a policy context for considering well-being within education. Mindfulness is not mandated by NEP 2020, and the policy should not be cited as evidence that mindfulness is effective. Rather, carefully adapted, voluntary activities may be considered one possible classroom support consistent with the policy's broader emphasis on holistic and inclusive education. Their use should remain evidence-aware, culturally responsive, and subordinate to the learner's individualized educational priorities.

Ethical Considerations, Challenges, and Precautions

- **Consent and assent:** Obtain informed consent from parents or legally authorized representatives where required, while also seeking the learner's assent in an accessible way. Ongoing willingness matters; consent is not a one-time permission to compel participation.
- **Voluntary participation and autonomy:** Learners must be able to decline, pause, or leave an activity without punishment or loss of privileges. Silence, stillness, or compliance must not be treated as proof of benefit.
- **Trauma-informed practice:** Eye closure, silence, body-focused attention, breath awareness, or particular sensory materials may be uncomfortable or triggering for some learners. Offer eyes-open alternatives, external attention tasks, movement, or a different activity [13]. Do not ask learners to revisit traumatic memories.
- **Privacy and dignity:** Emotional check-ins and observations should be handled confidentially. Learners should not be required to disclose feelings publicly or share personal experiences.
- **Safety and accessibility:** Consider allergies, swallowing risks, mobility, sensory sensitivities, medical conditions, and communication access. Activities involving food, movement, or sensory materials require appropriate safeguards [14].
- **Professional boundaries:** Educators should not claim to treat mental illness or replace clinical care. Refer concerns to qualified professionals and continue established support plans.
- **Equity and cultural responsiveness:** Offer language and activity choices that respect family and learner preferences. Avoid presenting mindfulness as culturally neutral or universally suitable.

Educational Implications

- Schools and special education institutions should treat mindfulness-informed activities as optional supports linked to identify learner needs, not as mandatory whole-class routines.
- Teacher preparation should include disability-responsive adaptation, communication access, sensory choice, trauma-informed safeguards, consent and assent, and referral boundaries.
- Evaluation should focus on outcomes meaningful to the learner: communication of comfort or distress, voluntary use of a chosen strategy, participation, self-advocacy, and perceived well-being where the learner can report it. Reduced movement or increased compliance should not be used as stand-alone success indicators [15].
- Institutions should involve learners and families in selecting culturally and linguistically appropriate activities. A quiet corner, breathing prompt, or sensory activity should never function as punishment, exclusion, or restraint.
- Future implementation should be evaluated for feasibility, staff workload, acceptability, adverse responses, and whether activities add value beyond existing communication, positive behaviour support, and mental-health services.

Limitations and Future Research

The evidence bases directly involving people with ID remains limited and heterogeneous. Several studies involve adults rather than school-aged learners; others examine staff or caregivers. Outcomes, programme duration, delivery format, sample size, and study design vary. It is therefore not possible to draw firm conclusions about the effectiveness of

Copyright© Solanki T.

mindfulness for all learners with ID or to identify a single best programme.

This review also has methodological limitations. The historical search date, exact search strings, and record counts were not retained, and no formal risk-of-bias tool was applied. The review should therefore be understood as a narrative synthesis rather than a comprehensive systematic review. These limitations reduce reproducibility and may mean that relevant studies were missed. Future research should include: (a) qualitative studies exploring learner experience, choice, and acceptability; (b) single-case experimental designs for individualized adaptations; (c) adequately powered controlled trials in school and community settings; (d) follow-up studies examining maintenance and generalization; (e) studies including learners with varied communication profiles and levels of support needs; and (f) research on adverse effects, implementation fidelity, staff training, family perspectives, and cost or workload[16]. Research in India should use culturally and linguistically responsive co-design with learners, families, and special educators.

Conclusion

Mindfulness-based practices may offer a complementary way to create opportunities for attention, emotional awareness, choice, and self-regulation among some people with intellectual disabilities. Current research is promising in selected adult, staff, and caregiver contexts, but direct evidence for school-aged learners remains limited. The findings should therefore be interpreted cautiously and should not be generalized beyond the populations and settings studied [17]. The central principle for educational use is individualization. Activities should be brief, concrete, accessible, voluntary, and responsive to communication, sensory, cultural, and functional needs. Special educators and families can contribute to safe implementation, while clinical concerns require qualified assessment and intervention. Mindfulness must never be used to suppress distress, enforce compliance, or replace established educational and health supports. The contribution of this review is a cautious synthesis of the available evidence and a practical assess–adapt–implement–monitor–adjust framework for considering mindfulness-informed activities in special education. Further research [18], especially with school-aged learners with ID in diverse contexts, is necessary to determine which approaches are acceptable, for whom, under what conditions, and with what meaningful outcomes.

References

1. American Association on Intellectual and Developmental Disabilities (End) Defining criteria for intellectual disability.
2. World Health Organization (2023) Disability and health.
3. Bishop S R, Lau M, Shapiro S, Carlson L, Anderson N D, et al. (2004) Mindfulness: A proposed operational definition. Clinical Psychology: Science and Practice 11(3): 230-241.
4. Kabat Zinn J (2003) Mindfulness-based interventions in context: Past, present, and future. Clinical Psychology: Science and Practice 10(2): 144-156.
5. Croom S, Chadwick D D, Nicholls W, McGarry A (2021) The experiences of adults with intellectual disabilities attending a mindfulness-based group intervention. British Journal of Learning Disabilities 49(2): 162-178.
6. Lake S, MacHale R (2022) "Mindfulness Matters": A pilot study of a Mindfulness-Based Stress Reduction group for adults with intellectual disabilities. British Journal of Learning Disabilities 50(3): 412–421.
7. Power N, Rawlings G H, Bennett C (2022) Evaluating a mindfulness-based group intervention for adults with intellectual disabilities. Advances in Mental Health and Intellectual Disabilities 16(3): 135-146.
8. Gandía Abellán H, Nieto C, García Rubio C (2023) Mindfulness for adults with autism spectrum disorder and intellectual disability: A pilot study. Journal of Intellectual Disabilities 27(4): 927–943.
9. Sturgeon M (2023) The impact of mindfulness interventions for staff on the care, treatment, and experiences of people with intellectual disabilities: A systematic review. Journal of Applied Research in Intellectual Disabilities 36(5): 978–999.
10. Donnchadha ÓS (2018) Stress in caregivers of individuals with intellectual or developmental disabilities: A systematic review of mindfulness-based interventions. Journal of Applied Research in Intellectual Disabilities 31(2): 181–192.
11. Yang T, Wang Y, Xu P, Tao Y (2026) The effectiveness of mindfulness-based interventions in improving the mental health of parents of children with intellectual or developmental disabilities: A systematic review and meta-analysis. Journal of Autism and Developmental Disorders 56(8): 2977–2991.
12. Government of India Ministry of Education (2020) National Education Policy 2020. Government of India.
13. Hwang YS, Kearney P (2013) A systematic review of mindfulness intervention for individuals with

Copyright© Solanki T.

developmental disabilities: Long-term practice and long-lasting effects. Research in Developmental Disabilities 34(1): 314–326.

14. Singh NN, Hwang YS (2020) Mindfulness-based programs and practices for people with intellectual and developmental disability. Current Opinion in Psychiatry 33(2): 86–91.

15. Solanki T (2024) Instructional planning.

16. Solanki T (2025) Creating an inclusive classroom & positive behavioural support [Book chapter]. ResearchGate.

17. Solanki T (2026) Significance of the National Education Policy 2020 in India's higher education system [Conference paper]. Conference on NEP–2020: Transforming Education, Inclusion and Innovations through Indigenous Wisdom. ResearchGate.

18. Solanki T, Panchal S (2025) Special educators as mental health advocates for students with intellectual disabilities. Indian Journal of Social Sciences and Literature Studies 11(2): 332–339.

Copyright© Solanki T.