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MENTAL HEALTH NEEDS OF CHILDREN WITH SPECIAL NEEDS: A REVIEW WITH SPECIAL REFERENCE TO JAMMU AND KASHMIR, INDIA

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Abstract

Children with special needs (CWSN) with intellectual, developmental, sensory, and physical disabilities have mental health needs that are often hidden by the primary focus on their disability, education and rehabilitation. This paper summarizes existing literature on the mental health needs of CWSN, including global and Indian studies on comorbid psychiatric disorders, caregiver stress, and access barriers to care, before focusing on Jammu and Kashmir (J&K). J&K has an unusual and unstudied setting where disability-related issues are intertwined with limited access to mental health services; inadequate regulation of rehabilitation facilities, poor identification and data management; and stigma. The review situates these findings against India's National Education Policy (NEP), 2020 and its commitments under the Sustainable Development Goals (SDGs), particularly SDG 3 (health and wellbeing), SDG 4 (education), and SDG 10 (reduced inequalities), showing that mental health support for CWSN is implied by commitments India has already made, even where the instruments meant to deliver them do not yet name it directly. The review finds a consistent pattern across the literature: psychiatric comorbidity among children with disabilities is well documented at the national level, caregiver mental health is increasingly well studied internationally, yet very little empirical research has examined the mental health needs of CWSN specifically within J&K's own health, education, and social service systems. It concludes by identifying priority gaps in research and practice and offering recommendations for integrating mental health support into disability services, inclusive education, and India's SDG monitoring in the region.

Keywords: *children with special needs; disability; mental health; Jammu and Kashmir; inclusive education; NEP 2020; Sustainable Development Goals; caregiver stress; stigma*

Introduction

An estimated 291 million children and adolescents under the age of 20 are thought to live with developmental disabilities or special educational needs globally, spanning intellectual disability, autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), epilepsy, and sensory impairments (Cheng & Lai, 2023). In India, national data place the number of children with special needs (CWSN) enrolled in schools in the millions i.e., 22.11 lakh CWSN were recorded across school managements nationally under UDISE+ 2025–26 data placed before the Rajya Sabha, with Jammu and Kashmir (J&K) alone accounting for 20,916 enrolled CWSN, only a fraction of whom attend schools with a dedicated special educator (Kashmir Life, 2026a). CWSN are typically discussed through the lens of educational access, rehabilitation, or physical care. Far less attention is paid to a parallel and equally important dimension of their wellbeing that is their mental health.

The mental health needs of CWSN are not only consequences to their disabilities but they are also an area that is rarely recognized as such. Children with intellectual disability, autism, or other developmental disorders have significantly higher rates of comorbid anxiety, depression, behavioural disorders, and other psychiatric disorders than the general child population. At the same time, families raising CWSN particularly mothers, who tend to be primary caregivers experience elevated rates of depression, anxiety, and chronic stress, which in turn shapes the emotional environment in which the child develops.

There are two purposes for this paper. Firstly, it integrates international and Indian data regarding the mental health needs of CWSN, including prevalence of comorbidity with psychiatric disorders, caregiver's psychological well-being, and access barriers to care. Secondly, it examines this evidence with a focus on Jammu and Kashmir, a region where the ordinary challenges facing CWSN and their families intersect with a severely constrained mental health workforce, an unevenly regulated private rehabilitation sector that has recently come under judicial scrutiny, weak data and identification systems, and persistent social stigma around both disability and mental illness. J&K is an

interesting and little studied example since these layers of vulnerability are compounding each other but very little research has been done on them as a whole.

The review also situates these findings against India's own policy commitments, the National Education Policy (NEP), 2020 and India's obligations under the Sustainable Development Goals (SDGs) to show that addressing the mental health of CWSN is not a demand external to existing policy, but a condition of fulfilling commitments the country has already made. The review closes by identifying gaps in research and practice and proposing directions for policy and service design.

Review Approach

This is a narrative review rather than a systematic review with a pre-registered protocol. It draws on peer-reviewed epidemiological studies and systematic reviews on child and adolescent mental health, disability, and caregiver mental health in India and globally, supplemented by government data (UDISE+) and recent field reporting on disability services in J&K, where peer-reviewed, region-specific research on CWSN mental health is scarce. This approach is a deliberate response to the evidence gap identified in Section 7, because very little peer-reviewed research examines CWSN mental health in J&K directly, the review triangulates across the disability and psychiatric comorbidity literature, the caregiver mental health literature, and contemporary reporting on service infrastructure in the region, while being explicit about where inference, rather than direct evidence, is being drawn.

Conceptualizing Children with Special Needs and Their Mental Health

In the Indian policy context, "children with special needs" is the term used within school education programs (such as Samagra Shiksha) to refer to children covered under the Rights of Persons with Disabilities (RPWD) Act, 2016, which recognizes 21 categories of disability spanning physical, sensory, intellectual, developmental, and mental illness-related conditions (Government of India, 2016). It’s an even wider, more diverse group of people than any one health condition does. Children who have disabilities are not all alike nor do they have identical mental health issues like those who are autistic and those who suffer from intellectual disabilities.

Mental health disorders and disabilities are conceptually separate yet overlapping areas of study empirically. Children with psychosocial disabilities are among the 21 recognized categories under the RPWD Act, and a child may have an intellectual or developmental disability without any diagnosable psychiatric disease.. However, comorbidity is prevalent and significant. In Barwani district, MP, India, a study of children with intellectual disabilities aged 3 to 18 years found that 80.9% of the sample had behavioural issues, 23.7% had epilepsy, 10.3% had enuresis, 6.5% had ADHD, 4.2% had autism, 2.7% had anxiety, and 2.3% had depression. Children with severe intellectual disability (IQ $\leq$ 49) were much more likely to have psychiatric disorders (Lakhan, 2013).. This severity gradient is important as it suggests that the children with the greatest support needs are also those at greatest psychiatric risk, and thus least likely to be reached by generic mental health services designed around verbal, cooperative patients.

A recent meta-analysis covering seven psychiatric disorders in India, including depression, anxiety, and intellectual disability, found on-going inconsistency across individual state level estimates, highlighting how thin and fragmented Indian child mental health epidemiology remains outside of a few well studied disorders (Dhiman et al., 2023). At the population level, a systematic review and meta-analysis of child and adolescent psychiatric disorders in India estimated community prevalence at 6.46% and school based prevalence at 23.33% (Malhotra & Patra, 2014). Reviews of child and adolescent mental health in India more broadly have also indicated that “special populations” including children with disabilities, orphans, and institutionalized children receive much less research and service attention than the general child population(Hossain & Purohit, 2019).

Classification also complicates it further. The RPWD Act (Government of India, 2016) has 21 categories to identify a CWSN, whereas clinical mental health services use diagnostic tools like the ICD or DSM. A child may be formally certified as disabled under one system for the purposes of school accommodations or a disability pension, while a simultaneous anxiety or mood disorder goes entirely unexamined because it falls under a different administrative and clinical pathway, taken care by different professionals, often in different physical locations. Fragmentation is a structural barrier to recognizing and responding to the mental health needs of CWSN, irrespective of any shortage of trained personnel.

Mental Health Needs of CWSN: Global and National Evidence

Beyond formal psychiatric comorbidity, CWSN face a set of everyday psychosocial stressors that shape their emotional development. Children with visible or behaviorally salient disabilities are disproportionately exposed to bullying, teasing, and social exclusion in mainstream settings, which contributes to low self-esteem, anxiety, and withdrawal. Children with autism spectrum disorder and other developmental disabilities frequently present with secondary anxiety and mood symptoms that are distinct from, but interact with, their core diagnosis a pattern well documented in the international literature on parenting stress and challenging behaviour in ASD (Catalano et al., 2018).

Access to appropriate mental health support for CWSN is also structurally difficult. Standard child mental health services are frequently designed around verbal, neurotypical assessment and treatment models that are poorly suited to children with intellectual disability, limited communication, or sensory impairments. Where inclusive education is available, teachers may lack training to recognize emotional distress in CWSN, and where it is not available, children may be entirely outside any institutional setting through which psychosocial difficulties could be identified. Reviews of Indian child and adolescent mental health services have repeatedly noted the absence of a dedicated policy architecture for these overlapping populations, despite India carrying one of the world's largest child and adolescent populations (Hossain & Purohit, 2019).

Age and developmental stage further shape how mental health needs present in CWSN. In early childhood, distress may appear as feeding or sleep disturbance, regression in previously acquired skills, or increased self-stimulatory or self-injurious behavior rather than as verbally reported sadness or worry. In middle childhood and adolescence, as social comparison with non-disabled peers becomes more salient, CWSN particularly those with milder or less visible disabilities such as specific learning disabilities or mild intellectual disability are at heightened risk of internalizing difficulties tied to repeated experiences of academic failure and exclusion from peer groups (Cheng & Lai, 2023).

A further theme relevant to the Indian context is diagnostic overshadowing, a phenomenon first identified by Reiss et al. (1982), in which clinicians and caregivers attribute a child's emotional or behavioral symptoms entirely to their underlying disability, rather than considering a co-occurring, independently treatable mental health condition. Diagnostic overshadowing has been documented across intellectual disability populations internationally (Reiss et al., 1982) and is a plausible contributor to the low reported rates of formally diagnosed anxiety and depression in some Indian CWSN samples relative to the much higher rates of caregiver-reported behavioral difficulty (Lakhan, 2013), that is, low diagnosed prevalence may reflect under-recognition rather than a true absence of need.

The Jammu and Kashmir Context

Health, Rehabilitation, and Educational Infrastructure

J&K's mental health workforce is severely constrained even relative to the rest of India, which itself falls well short of global benchmarks, rural India as a whole has been estimated at around 0.75 psychiatrists per 100,000 population, against a World Health Organization-recommended benchmark of 1.7 (Singh et al., 2025). Rehabilitation infrastructure specifically for CWSN in J&K shows a similarly constrained pattern. Government Medical Colleges and district hospitals across the region offer very limited in some districts, no early intervention services for children with disabilities, and even where services exist they frequently lack accessibility features, trained professionals, or child-friendly facilities (Kashmir Times, 2026).

This gap has driven a proliferation of private Child Development and Rehabilitation Centres (CDCs), a substantial number of which reportedly operate without proper registration, qualified staff, or regulatory oversight. A 2025 inspection by the Child Welfare Committee, Srinagar, of several such centres led to a Public Interest Litigation before the Supreme Court of India seeking mandatory registration, professional verification, and grievance mechanisms for CDCs under the RPWD Act (Kashmir Times, 2026). Families who cannot access public services, or who travel from outlying districts to reach private centres concentrated in Srinagar, absorb both the direct cost of therapy and the indirect cost financial and psychological of frequent travel, a burden reported to contribute to distress among parents themselves (Kashmir Life, 2025a).

On the education side, UDISE+ 2025–26 data recorded 20,916 CWSN enrolled across schools in J&K, with only 1,772 schools reporting a dedicated special educator (Kashmir Life, 2026a) implying that the great majority of enrolled CWSN attend schools without dedicated specialist support. Reporting on inclusive education in J&K has also highlighted weak identification and data-collection mechanisms, meaning that children who are not enrolled, or whose disability is unrecognized or undisclosed, are effectively invisible to the system (Rising Kashmir, 2025).

Stigma and Socio-Cultural Factors

Stigma surrounding both disability and mental illness compounds these infrastructural gaps. Reporting from J&K describes families who conceal a child's disability from their community for fear of social rejection, and teachers who hold unconscious biases that marginalize CWSN within mainstream classrooms (Rising Kashmir, 2025). This is consistent with the broader Indian literature on mental health stigma, which identifies stigma and discrimination as a central driver of the mental health treatment gap, operating through delayed care-seeking, internalized self-stigma among affected individuals and families, and reduced social participation (Shidhaye & Kermode, 2013).

Qualitative work on rural Indian mental health care has similarly found stigma cited by a majority of caregivers as a decisive barrier to formal help-seeking, alongside reliance on traditional healers and low mental health literacy (Singh et al., 2025). For a child who is both disabled and, potentially, symptomatic of a mental health condition, these layers of stigma can compound, disability-related stigma affecting school inclusion and social participation, and mental-illness-related stigma separately affecting willingness to seek psychiatric or psychological support even where services are physically accessible.

Enforcement of the legal framework in J&K also lags behind its formal guarantees. The RPWD Act, 2016 is described in regional reporting as far from being enforced in practice, with private schools widely refusing admission to CWSN despite the legal mandate, and accessibility infrastructure such as ramps largely absent from government buildings and educational institutions (Rising Kashmir, 2025). The 2025 Supreme Court PIL concerning unregulated CDCs illustrates this gap concretely, legislation exists to require registration and professional oversight of rehabilitation providers, but enforcement had, by the time of the PIL, plainly not kept pace with the private sector's growth in response to unmet public demand (Kashmir Times, 2026).

Family and Caregiver Mental Health

The mental health of CWSN will not be considered in isolation from the mental health of their caregivers, who are usually mothers functioning as primary carers. A systematic review and meta-analysis of parents of children with intellectual and developmental disabilities found regularly elevated rates of depression and anxiety compared with parents of typically developing children, attributable to increased caregiving demands, financial strain, and, in many cases, social isolation (Scherer et al., 2019). A separate systematic review of parental stress specifically among families of children with special educational needs covering 26 studies and over 5,000 parents identified four recurring risk and protective factors, the sex of the parent (with mothers typically reporting higher stress), diagnosis-related coping difficulties, socioeconomic circumstances, and social isolation (Cheng & Lai, 2023). Evidence specific to parents of children with autism spectrum disorder similarly points to elevated stress, depression, and anxiety, with intervention effectiveness closely tied to parents problem-solving skills and self-perspective-taking (Catalano et al., 2018).

In the J&K context, several of these risk factors are likely to be amplified rather than offset. Financial strain is compounded by the cost and travel burden of accessing rehabilitation services concentrated in Srinagar (Kashmir Life, 2025a), social isolation may be compounded by stigma-driven concealment of a child's disability within the community (Rising Kashmir, 2025); and general rural Indian evidence on caregiver burden shows that distance, cost, and stigma interact to delay and discourage help-seeking even where services exist (Singh et al., 2025). This suggests that caregiver mental health support largely absent from current CDC and school-based service models in J&K is not a peripheral add-on but a structurally important component of any effective response to the mental health needs of CWSN in the region.

Policy and Systemic Response

India's legal and policy framework formally recognizes both disability rights and the case for inclusive education. The RPWD Act, 2016 guarantees equality and non-discrimination for persons with disabilities and mandates

accessibility across public institutions (Government of India, 2016), the Right to Education (RTE) Act, 2009 establishes free and compulsory education and the Mental Healthcare Act, 2017 establishes a rights-based framework for mental health care generally, without a distinct CWSN-focused provision.

The National Education Policy, 2020

The National Education Policy (NEP), 2020 is the most significant recent statement of India's commitment to inclusive education for CWSN. Paragraphs 6.10 to 6.14 of the Policy deal specifically with provisions and strategies for children with disabilities, and the Policy states explicitly that it is in complete consonance with the RPWD Act, 2016 and endorses that Act's recommendations for school education (Government of India, 2020). NEP 2020 commits to enabling children with disabilities to participate fully in the regular schooling process from the foundational stage through higher education, and directs that schools and school complexes be provided resources for the integration of CWSN, including the recruitment of special educators with cross-disability training and the establishment of resource centres for children with severe or multiple disabilities (Government of India, 2020). The Policy further envisages accommodations and support mechanisms tailored to individual need, assistive devices and technology-based tools, and accessible teaching-learning material such as large-print and Braille textbooks.

These commitments are given financial and administrative form through the Samagra Shiksha scheme, which has been realigned to NEP 2020 and now provides identification and assessment of CWSN, aids and appliances, corrective surgeries, therapeutic services, in-service training of special educators and general teachers, and a defined per-child support norm, with entitlement running from early childhood care and education through the senior secondary stage (Government of India, 2020).. The gap identified throughout this review is not an lack of policy ambition but a gap in the mental health dimension of that ambition. NEP 2020's CWSN provisions are framed overwhelmingly around access, curriculum adaptation, and physical or sensory accommodation, with no explicit provision for psychosocial or mental health support as part of the resource centre or special educator model it establishes. In J&K specifically, the deficit between the number of CWSN enrolled and the number of schools with a dedicated special educator (Kashmir Life, 2026a) suggests that even the access-oriented commitments of NEP 2020 remain unevenly realized, well short of the point at which a mental health component could meaningfully be added.

Alignment with the Sustainable Development Goals

The mental health needs of CWSN in J&K also sit directly within India's commitments under the United Nations 2030 Agenda for Sustainable Development, which references disability explicitly across several Sustainable Development Goals (United Nations, 2015). SDG 3 (Good Health and Well-Being) commits countries, under Target 3.4, to promote mental health and wellbeing as part of reducing premature mortality from non-communicable disease (United Nations, 2015), read alongside the psychiatric comorbidity evidence in Section 2, this target applies with particular force to CWSN, whose elevated psychiatric risk (Lakhan, 2013) is rarely the subject of dedicated mental health promotion or treatment effort in J&K's current service model. SDG 4 (Quality Education) commits, under Target 4.5, to eliminating gender disparities and ensuring equal access to education for the vulnerable, including persons with disabilities, and under Target 4.a, to building and upgrading education facilities that are child and disability sensitive (United Nations, 2015), NEP 2020's CWSN provisions (Section 6.1) are the domestic instrument through which India intends to meet this target, and the enrolment and special-educator data reviewed in Section 4.1 indicate how far J&K remains from it in practice. SDG 10 (Reduced Inequalities) commits, under Target 10.2, to promoting the social, economic, and political inclusion of all, irrespective of disability status (United Nations, 2015), the stigma-driven concealment of disability and the exclusion of CWSN from mainstream schooling documented in J&K (Rising Kashmir, 2025) run directly counter to this target.

Framing the mental health needs of CWSN in J&K through NEP 2020 and these SDG targets does two things. First, it makes explicit that mental health is not an optional addition to inclusive education and disability policy, but a component already implied by commitments India has made to mental health and wellbeing under SDG 3, to genuinely equal educational access under SDG 4, and to full social inclusion under SDG 10 even where the domestic instruments intended to deliver them, such as NEP 2020, do not yet name it directly. Second, it gives the recommendations in Section 9 a policy anchor, strengthening the mental health content of the Samagra Shiksha/NEP 2020 CWSN framework, and monitoring J&K's progress against SDG 3, 4, and 10 targets specifically for its CWSN population, would convert existing national commitments into a concrete local accountability mechanism, rather than requiring an entirely new policy instrument.

Implementation Gap in Jammu and Kashmir

As discussed in Section 4.2, reporting and commentary on J&K consistently describe a substantial gap between these legal and policy mandates the RPWD Act, NEP 2020, and by extension India's SDG 3, 4, and 10 commitments and their enforcement on the ground, spanning school admission practice, physical accessibility, and regulation of the private rehabilitation sector (Rising Kashmir, 2025; Kashmir Times, 2026). This implementation gap is the central practical obstacle standing between the policy architecture reviewed above and any meaningful improvement in the mental health of CWSN in the region.

Gaps in Research and Practice

This review surfaces a clear structural gap in the evidence base, national-level research on the mental health of children with disabilities in India (Dhiman et al., 2023; Lakhan, 2013; Malhotra & Patra, 2014) and region-specific reporting on CWSN service infrastructure in J&K (Kashmir Life, 2026a; Kashmir Times, 2026; Rising Kashmir, 2025) exist as largely separate bodies of evidence. No peer-reviewed study identified in this review directly examines the mental health outcomes of CWSN within J&K's own health, education, and social service systems.

Related gaps include the absence of validated, developmentally and culturally appropriate mental health screening instruments for use with non-verbal or intellectually disabled children in the Kashmiri context, very limited data on rural and remote districts, where both disability services and mental health services are thinnest, the near-total absence of caregiver-focused mental health interventions embedded within existing CDC or school-based CWSN services compare Catalano et al. (2018) and Scherer et al. (2019) neither of which draws on Indian samples and weak routine data collection on CWSN generally, which limits even basic epidemiological description of the population's needs (Rising Kashmir, 2025).

Assessment and Intervention Considerations

Any response to the mental health needs of CWSN in J&K must reckon with the limits of standard assessment and treatment models. Widely used child mental health screening tools were developed for general child populations and require adaptation in content, administration, and interpretation before they can be reliably used with children who have limited verbal communication, intellectual disability, or sensory impairments. Caregiver-report and observational measures, rather than self-report, are typically necessary for this population, which in turn makes caregiver mental health and caregiver reporting burden directly relevant to the accuracy of any assessment, not simply a parallel concern (Cheng & Lai, 2023).

On the intervention side, settings with severe specialist shortages a description that applies acutely to J&K (Singh et al., 2025) commonly rely on task-shifting models, in which briefly trained community health workers, teachers, or lay counsellors deliver structured psychosocial interventions under the supervision of a smaller number of specialists. Such models are plausibly well suited to J&K's combination of specialist scarcity and existing, if strained, networks of frontline health and education workers who already have some contact with CWSN and their families. However, no published evaluation of a task-shifted mental health intervention specifically for CWSN in J&K was identified in this review, again reflecting the broader evidence gap described in Section 7.

Recommendations

Based on the evidence reviewed, several directions for policy, service design, and research warrant priority attention.

1. Mental health screening and basic psychosocial support should be integrated into existing CDC, rehabilitation, and special-education services, rather than treated as a separate referral pathway that families must independently navigate.
2. The ongoing regulatory push for CDC registration and oversight (Kashmir Times, 2026) should explicitly include minimum standards for identifying and responding to mental health and behavioral concerns, not only physical and developmental therapy.
3. Teachers and special educator currently present in only a fraction of schools enrolling CWSN (Kashmir Life, 2026a) should receive basic training in recognizing emotional distress in children with communication or intellectual impairments, with attention to non-verbal and behavioral indicators rather than reliance on verbal disclosure.

4. Caregiver focused mental health support (psychoeducation, peer support groups, and where feasible brief psychological interventions) should be built into CWSN service delivery, given the well-documented mental health toll on parents and caregivers (Cheng & Lai, 2023; Scherer et al., 2019).
5. Mental health and rehabilitation services should be deliberately decentralized beyond Srinagar, potentially through task-shifted models built on existing community health and education workforces, to reduce the travel and financial burden currently borne by families in outlying districts.
6. Identification and data-collection systems for CWSN should be strengthened so that children who are unenrolled, undiagnosed, or whose families conceal their disability due to stigma are not rendered invisible to planning and resource allocation.
7. The mental health component missing from NEP 2020's CWSN provisions (Section 6.1) should be made explicit within the Samagra Shiksha resource-centre and special-educator model, and J&K's progress on CWSN mental health should be tracked as part of the state's reporting against SDG 3, 4, and 10 targets, so that these existing national commitments create real local accountability.
8. Finally, a dedicated research agenda is needed to generate empirical, J&K-specific data on the mental health of CWSN, including validation of assessment tools appropriate for children with limited verbal communication.

Conclusion

Children with special needs carry a burden of mental health risk that is well documented in the general disability literature but rarely examined in conjunction with the specific stressors of their local environment. In Jammu and Kashmir, this gap is especially consequential, a population of children already facing elevated psychiatric comorbidity (Lakhan, 2013) is also growing up within a thin, unevenly regulated rehabilitation and education system (Kashmir Life, 2026a; Kashmir Times, 2026), against a backdrop of persistent stigma (Rising Kashmir, 2025; Shidhaye & Kermode, 2013) and one of the most stretched mental health workforces in India (Singh et al., 2025). India's own policy architecture NEP 2020's provisions for CWSN and its stated commitments under SDG 3, 4, and 10 already implies that mental health cannot be separated from educational access, health equity, and social inclusion for this population; what is missing in J&K is not the policy rationale but its implementation and its explicit extension to mental health. Addressing the mental health needs of CWSN in J&K will require moving beyond parallel, single-issue responses disability services on one hand, general mental health services on the other toward integrated models that treat the two as inseparable, and toward monitoring that holds implementation accountable to the commitments already on paper. It will also require a deliberate research effort to replace the current reliance on inference across separate literatures with direct, context-specific evidence.

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