

EFFECTIVENESS OF LIFE SKILLS TRAINING PROGRAM TO ENHANCE MENTAL HEALTH STATUS AND WELL BEING OF YOUNG PEOPLE, AN INTERVENTION STUDY

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ABSTRACT

The aim of the study is to assess the effectiveness of a life skills training program to enhance mental health status and well being of young people. A classical experimental research design with a control group (pre, post, and follow-up intervention) and random sampling method were used. The present study comprised girls and boys in the age group of 16 to 19yrs, studying in plus one and plus two classes from Ernakulum Educational District of Kerala. The respondents were selected on the basis of inclusion and exclusion criteria and also evaluated the mental health status by GHQ-28 and mental well being by WEMWS-14. The 720 respondents from six Higher Secondary Schools (3 Govt. schools and 3 Pvt. Schools: 1 boys, 1 girls and 1 co-edu. schools) were randomly selected and distributed in two mentioned groups such as 360 students in intervention group and 360 students in control group (180 boys and 180 girls from each group). The researcher conducted life skills training program (10 – 12 sessions in five weeks) to the intervention group and again the same assessment tools were administered for post-intervention (one – three months) and follow -up intervention (six- nine months) to evaluate the effectiveness of intervention program to enhance mental health status and well being of the respondents.

The current version of the Statistical Package for Social Sciences (SPSS) was used to analyze the data and correlations were obtained. Repeated Measures Analysis of Variance (RMANOVA) was performed to test whether there is any significant effect due to interventions in the scores. Independent sample t-test was performed to compare the equality of baseline scores of various components of the mental health status and well being of the two groups. The data were analyzed by descriptive and inferential statistics in three-time lines (pre, post and follow- up intervention) under different sections. The result shows that there was a highly significant intervention effect between the scores of mental health status and well being. The researcher has noticed that a tremendous number (100% in mental health status and 99.1% in mental well being) of respondents in each group were benefitted by the intervention program. This indicates the need for periodic and constant intervention for the respondents. Hence, it can be concluded that life skills training program is effective for enhancing mental health status and well being of young people.

KEYWORDS: Mental Health, Well Being, Young People, Life Skills

INTRODUCTION

An individual's mental health and wellbeing are significantly affecting their path through life, and they are very much important for the healthy functioning of families and society as a whole, together they affect the social cohesion and prosperity of the nation. Childhood and adolescence are crucial periods for laying the foundations for healthy development and good mental health. Poor mental health in childhood is associated with increases the risk in life and other adverse outcomes in adulthood. Both of these concepts of mental health and well being are intimately linked, and measures to address one will often affect the other, this argues that it is essential to be considered together when designing the intervention program (Kieling C. et al., 2011).

Mental health refers to our cognitive, behavioral and emotional well being and it is all about how we think, feel and behave. The term mental health is sometimes used to mean an absence of a mental disorder. Mental health can affect daily life, relationships and even physical health. The concept of mental health status encompasses both cognitive and emotional resources. It includes people's cognitive ability; their flexibility and efficiency at learning; and their 'emotional intelligence', or social skills and resilience in the face of stress. It is "the metaphorical bank account of the mind", which gets enhanced or depleted throughout the life course. Furthermore, the term mental wellbeing is referred to an individual's ability to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community (Nature, 2008; Beddington et al., 2008; <https://www.medicalnewstoday.com/article/2017>).

Young age is characterized by rapid physical, mental, moral and social growth. Besides physical maturation, cognitive development is also visible. Youth is a period characterized by a time of indecision, despair, and doubt, especially in instances where they are not mentally conditioned and physically prepared to cope with the changes taking place in and around them. Young people today are caught up in an identity crisis, one which is not easy to define. According to Erikson's definition, "crisis does not mean breakdown or catastrophe but rather a 'crucial period' when stable reference points in and around the young person must be established"- Young people cannot wait, because it is a period which is fleeting (Erickson, 1950, 1963, 1968). As per the Indian education system, children in the age group of 13-19yrs undergo some major milestones of their academic career during this time. The standard age for a student who takes the class 10 board exam is 14 -15 and that of a student who takes the class 12 board exam is 16 -17. The board exams can trigger immense stress and anxiety among students which makes the role on schools immensely important. Hence the researcher has been selected respondents from +1 and +2 classes for the proposed research.

Significance of the Study

The present study is significant today, because most young people are presumed to be healthy but, as per World Health Organization an estimated 2.6 million young people aged 10 to 24 years die each year and a much greater number of young people suffer from illnesses 'behaviors' which hinder their ability to grow and develop to their full potential (WHO, 2004). There are good evidence that mental health promotion programs in schools lead to positive mental health, social and educational outcomes among the students (Weare K, Nind M, 2011; Guardian, 2017). Intervention Programs incorporating life skills, social and emotional learning and early interventions to address emotional and behavioral problems, produce long-term benefits for young people, including improved emotional and social functioning, positive

health behaviours, and improved academic performance (Durlak J. A, et al., 1997 & Rowling L, et al., 2003). World Health Organization has [been](#) addressed life skill-based education since the 90s and [others](#) are now taking notice (WHO 1996, 1997; Bhav Swati, 2005; Vranda, 2015; Guardian, 2017; MINDS foundation, 2017; WFMH-Report, 2018). In a constantly changing environment, having life skills is an essential part of being able to meet the challenges of everyday life.

Global Perspective of Mental Health and Well Being of Young People

As per the report of Global Youth Wellbeing Index (2014), 15 % of the total youth across the 30 countries are experiencing high or upper - the middle quality of life, while 85% are experiencing lower - middle and low well being (including India). Overview of the global situation, mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1959). According to the recent adoption of Global Mental Health Action Plan (2013-2020) slogan, "No health without Mental health" is an encouraging step towards developing national mental health policies, increasing funding, strengthening information systems, research and integrating essential mental health services in line with WHO vision (WHA, 2013). Happy and confident youth are most likely to grow into happy and confident adults, who in turn contribute to the health and well-being of nations. Mental health problems among young people carry high social and economic costs, as they often develop into more disabling conditions later in life. World Health Organization estimated that mental health problems and behavioral disorders account for about 12 percent of the global burden of diseases (WHO, 2001).

National Perspective of Mental Health and Well Being of Young People

Young people are one of the precious resources in every country. India has the largest youth population in the world with around 550 million young people (Census 2011). 70% of India's population is below the age of 35 years. This pool needs to be engaged in the mainstream development of the country. And it is indeed vital to utilize this demographic dividend and channelize the youth and their creative energies for nation-building. World Health Organization defines 'adolescence' as age spanning 10 to 19 years, 'youth' as those in 15-24 yr age group and these two overlapping age groups as "young people" covering the age group of 10-24 yrs (WHO, 2001). Mental health issues are acquiring a serious magnitude in our country. The National Mental Health Survey found that children and young people are most vulnerable to mental health problems especially those living in metropolitan cities – whether in the productive age group, or children and teenagers (NMHS, 2016). According to the report of World Congress of Mental Health, around 14 per cent of India's population, especially children and adolescents required active intervention programs for mental health promotion and well being (Delhi, November 2, 2017). This is the time to invest in strategic policies, partnerships and effective intervention programs that engage and equip the young people to be productive and it helps them to realize their potential. If this transformative generation can be given the tools they need to thrive, then they will be able to contribute the best for nation building (Nicole Goldin, 2014). World Mental Health Day 2018 theme - "Young people and mental health in a changing world"- shows the importance of creating more services and better care for our young people. The acts of prevention, early interventions, resilience, available information, and services are the key factors in creating a healthy future for our young people (WFMH-Report, 2018; <https://wfmh.global/wmhd2018/>).

Young people's health is vital and crucial; young people in the age group of 10 - 24 years in India constitutes one of the precious resources of the country, every third person belonging to this age group, characterized by growth and development and is a phase of vulnerability often influenced by several intrinsic and extrinsic factors that affect their health and safety, early learning in children can increase their coping skills and resilience to stress and common mental disorders. Later in life, this resilience helps to engender well-being at work and into old age, intervention increases the chance of preventing long term negative outcomes and promoting mental health status and well-being. So, the youth mental health promotion program in the school setting is very relevant today to prevent mental illness and promote mental health and well-being (WHO, 1997).

Mental Health and Well Being of Young People an Area Specific Understanding

The educational philosophy, which is currently prevalent in our country is achievement oriented than child-oriented and also, it does not address the integral development of the child. While Kerala, a southern state of India is on the top for various indices of health compared to the rest of the states in the country, it is not so with respect to mental health. Recent reports in the newspapers and national / international journals bring dismay pictures of the increasing problems of adolescents in India, especially in Kerala, where the social, health, economic and educational advancement has taken place. Issues like Child sexual abuse, substance abuse, suicide attempts, etc. are becoming a curse in the so-called erudite and cultured Kerala society.

Recently it is observed that psycho-social problems are prevalent among Kerala's adolescents and young people (Mumthas, 2014). Of late the tendency to use / abuse tobacco-based products and other substances, drugs and alcohol are on an alarming rise among the young in Kerala. It causes terrible problems in families, schools, colleges, and society as a whole. Teachers and parents and others become helpless in front of this spreading tragedy. This situation needs to be studied, and it is our responsibility to take up the youth with effective intervention program, hence the researcher gave more focus on school-going young people. Early intervention and life skills training programs would be beneficial for reducing crime, improving productivity, increase coping skills and resilience to stress and preserving mental health status and well-being in older age (Cooper et al., 2009; Corey, 2013). In school-based programs for adolescents, the teaching of life skills in a supportive learning environment can do this. Life skills are essentially those abilities that help promote mental well being and competence in young people as they face the realities of life (WHO, 1994). Many of these interventions showed beneficial effects in promoting resilience and reducing the risk of developing mental health problems such as anxiety and depression. Some of these interventions are also included in systematic reviews of studies which to aim prevent mental health problems and promote mental health and well being of young people. In this particular context, the researcher seeks to capture the quality of participation of young people in a competitive world and aims to prove that life skills training program in the school setting is effective for enhancing mental health status and well being of young people.

Specific Objectives

- To assess the mental health status of young people
- Level of somatic symptoms
- Level of anxiety symptoms
- Level of social dysfunction

- Level of severe depression
- To assess the mental well being of young people:
- To assess happiness and life satisfaction
- To assess the good relationships and self-realization
- To study the effectiveness of a life skills training program.

Hypothesis Corresponding to the Objectives

Alternative hypothesis based on mental health status

- Post-interventional reduction in the level of somatic symptoms is greater in the intervention group than the control group
- Post-interventional level of anxiety symptom in the intervention group is lesser than that of the control group
- The post-interventional level of social dysfunction in the intervention group is lesser than that of the control group.
- Post-interventional level of severe depression in the interventional group is lesser than that of the control group

Alternative hypothesis based on mental well-being

- The level of happiness and life satisfaction in the intervention group is greater than that of the control group in the post-interventional phase
- The level of good relationships and self-realization is greater in the intervention group than the control group after the intervention

Null Hypothesis

- School-based life skills training program has no impact on the mental health status and well being of young people.

Research Design

A classical experimental research design with a control group and simple random sampling method were used. Pre-post -and follow - up intervention were taken place. The key variables targeted in this investigation are mental health status and well-being. Data was collected by using a demographic performance and Statistical tools of General Health Questionnaire (GHQ-28) and Warwick Edinburg Mental Well Being Scale (WWEMWBS -14). The participants for the study comprised of 720 school going young people both boys and girls, between the age group of 16 to 19 years from six higher secondary schools in Ernakulum educational district of Kerala, meeting the inclusion and exclusion criteria through simple random sampling. Informed written consent will be obtained from the participants prior to the study. In each school out of the several sections, two divisions of the +1 and +2 section will be selected. And they will be sequentially assigned to the intervention group and control group. Hence the group comprised of 360 children (180 girls and 180 boys) in the

intervention group and 360 (180 girls and 180 boys) in the control group (60 students from each school as intervention group as well as the control group).

Operational Definitions of Keywords

Mental Health According to World Health Organization, mental health is defined as a state of well being in which individuals are able to realize their own abilities and potential, can cope with the normal stresses of life, work productively and fruitfully, and are able to contribute the best to their community(WHO, 2004).

Well Being Wellbeing refers to an individual's ability to develop their potential, work productively and creatively, build strong and positive relationships with others and contributes to their community (WHO, 2004; Beddington et al., 2008).

Young People There are various definitions of young people / youth population by WHO and UNICEF. According to the National Youth Policy of India (2003), young people define as those in the age group of 15 - 35 yrs. In the current study, the researcher refers to young people as an individual between the age group of 16years to 19 years.

Life Skills According to the world health organization, life skills as "the abilities for adaptive and positive behavior that enable individuals to deal effectively with demands and challenges of everyday life" (WHO, 1994). People having life skills could be able to make informed decisions, communicate effectively and develop coping and self-management skills that may help an individual to lead a healthy and productive life.

Universe of the Study (Population) The universe of the study consists of the school going young people, who are studying in higher secondary schools in Kerala.

Unit of study (Sample) The study population consists of 720 young people, both male and female in the age group of 16 - 19 years, from +1 and +2 classes of three Govt. schools and three Pvt. aided schools (2- boys schools, 2- girls schools and 2- co-education schools) in Ernakulum Educational Districts of Kerala. The population divided into two groups such as the waitlisted group / control group (360) and the experimental group / intervention group (360) for determining the effect of the intervention package comparatively.

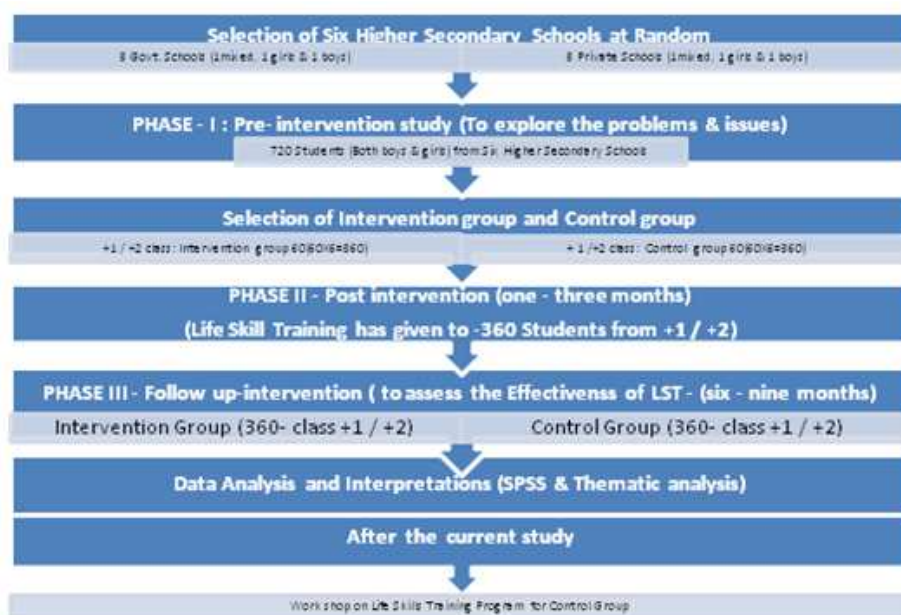


Figure 1: Flow Chart Random Sampling Procedure

The Respondents were Selected by Inclusion and Exclusion Criteria which are stated below

Inclusion criteria

- young people in the age group of 16 to 19 years who are studying in +1 & +2 classes
- young people attending school regularly
- young people who can read, write and speak English and Malayalam languages
- young people giving assent and having parental consent to participate in the program.

Exclusion Criteria

- Young people with severe or chronic physical illness or neurological illness
- Young people with a diagnosed psychiatric illness and or disorders such as ADHD, LD, CD, etc. and who are currently receiving psychotherapy and medication
- Young people with previous exposure to life skills training in the past two years.

Ethical Issues

- Ethical clearance has been obtained from the university ethical committee of Don Bosco University, Guwahati Assam to carry out the study
- The adolescent children involved in the study have been explained clearly about the purpose and nature of the study. They will be assured that any information they disclose will be used only for the study purpose and keep strictly confidential
- Informed consent will be obtained separately from all the participants before proceeding the study

- The children with problems will be provided professional help in consultation with their teachers and parents by the researcher by making appropriate referral services as and when required.
- The respondents will be asked to feel free to drop out the study at any given point of time without having to give any explanations for the same.

The Three Phases three Time Lines of the Proposed Research are the Following

Phase 1

Pre-Intervention

To explore the psychosocial problems and issues of young people, by using the standard tools such as GHQ-28 and WEMWS- 14. The focus of researcher in this phase is to assess the baseline scores of mental health status and well being of school going young people and to know more about the need for school-based intervention program.

Phase 2

Post Intervention

To implement Life skill training program as a model of a group intervention to enhance mental health status and well-being. The intervention package could be developed based on the available modules on life skills education for children and adolescents by world health organization (WHO, 1993a) and life skills education for children in the school setting - Nimhans model(Vrunda &Sekar, 2008). The intervention program was conducted once in a week and completed 10 - 12 sessions (2 - 2 ½ hour per session) in each school. The post-intervention has been done in between one month to three months of the intervention program with the same assessment tools which are used for the pre-intervention phase.

Phase 3

Follow up Intervention

The follow up intervention was conducted after six months to nine months of the intervention program by using the same assessment tools, which was used for pre and post-intervention and prepared the statistical analysis and interpretations regarding the effectiveness of life skills training program to enhance mental health and well being of young people.

How the Intervention has been Conducted?

- Content of intervention : Life Skills Training program
- Mode of delivery : Group – based (one to one if needed)
- Frequency of inputs : Once in a week
- Duration / length of inputs : 2 – 2 ½ hrs per session
- Number of members in group : 60 participants (two groups)
- Nature of group : Closed group
- Total no. of sessions : 10 - 12 sessions and one day workshop

Life skills training is aimed at facilitating the development of psycho-social skills that are required to deal with the demands and challenges of everyday life. WHO department of mental health identified the 10 core life skills that are relevant across culture, are the following: (WHO, 1998)

CLASSIFICATION OF LIFE SKILLS – WHO - MODEL

Ten Core Life skills have been classified into three broad categories as follows

- Social Skills: Self Awareness, Effective communication, Interpersonal relationship, Empathy
- Thinking Skills: Creative thinking, Critical thinking, Decision making, Problem-solving
- Emotional Skills: Coping with stress and Coping with emotions.

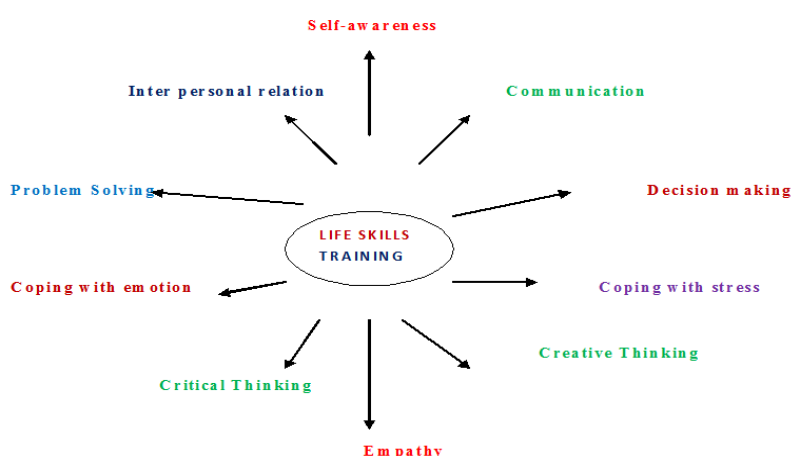


Figure 2: Pictorial Representation of the Ten Core Life Skills (WHO)

Table 3: Quality Standards for Life Skills Education

Standard 1	Standard 2	Standard 3	Standard 4	Standard 5
Out comes	Assessment	Activities	Teaching	Learning environment
Life skills education is need based (child centered)	Life skills learning is result - based	Life skills learning is knowledge, attitudes and skills - based	Teachers are trained on methods and psycho-social support	Life skills education is provided in protective and enabling environments with access to community services

Source: www.centalsquarefoundation.org, 2016

Tools Used For Data Collection

The following tools were used for data collection

- Assessment / Screening tools

- Socio-Demographic Sheet and Questionnaire (SDSQ)
- Semi-structured Interview Schedule to Assess General Health Problems (SISAGHP)
- Family Function Assessment Sheet (FFAS)
- General Health Questionnaire (GHQ -28) – Goldberg, D.P. et al (1997): GHQ is used to assess the mental health status. GHQ is widely used by researchers in various fields (occupational health, medicine, psychology, Medical and psychiatric social work, etc.) and clinicians who wish to screen individuals for mental health problems. It is often of more interest to be able to examine a profile of scores rather than a single score, making this version of the GHQ particularly useful. It contains 28 items that, through factor analysis, have been divided into four subscales. The GHQ-28 is the most well-known and popular version of the GHQ. This ‘scaled’ version of the GHQ has been developed on the basis of the results of principal component analysis. The four sub-scales, each containing seven items, are as follows
 - Somatic Symptoms (items 1 – 7)
 - Anxiety Symptoms (items 8 – 14)
 - Social Dysfunction (items 15 – 21)
 - Severe Depression (items 22 – 28)

As suggested by Goldberg, the Likert scoring method was adopted, because the Likert scoring method will produce a wider and smoother score distribution if a researcher wishes to assess the severity of the problem, the higher the score, the more severe the condition. The Likert scoring pattern 0-1-2-3 was adopted by the researcher. GHQ 28 has been allowing for more valid comparisons.

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS - 14)

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) comprises 14 items that relate to an individual's state of mental well-being (thoughts and feelings) in the previous two weeks. Responses are made on a 5-point scale ranging from ‘none of the time’ to ‘all of the time’. WEMWBS aims to measure mental well-being itself and was developed through research that was conducted at Warwick and Edinburgh Universities (Tennant *et al.*, 2006). Working iteratively with members of the advisory group this new scale was refined to the 14 item scale. Validation to date has been performed in the UK with those aged 16 and above. (Tennant *et al.*, 2006; 2007). Each of the 14 item responses in WEMWBS is scored from 1 (none of the time) to 5 (all of the time) and a total scale score is calculated by summing the 14 individual item scores. The minimum score is 14 and the maximum score is 70.

Statistical Analysis of the Data

The current version of the Statistical Package for Social Sciences (SPSS) was used to analyze the data and correlations were obtained. Repeated Measures Analysis of Variance (RMANOVA) was performed to test whether there is any significant effect due to interventions in the scores. Independent sample t-test was performed to compare the equality of baseline scores of various components of the mental health status and well being of the two groups.

Analysis Part I

This comparative study between the two groups (control group and intervention group) can be considered effective only when the two groups are homogeneous in every aspect. To study the independence of the groups for these characteristics Karl Pearson’s Chi-square test for independence is used. Chi-square test demands the expected frequency of every cell to be more than or equal to 5. Suppose any of the expected frequency is less than 5, then Cramer’s V statistic is the appropriate measure to be used to study the independence of the two characteristics. Cramer’s V statistic doesn’t demand the expected frequency to be more than or equal to 5. The null hypothesis stating ‘the two characteristics, one being the group, are independent’ is tested using either Chi-square test for independence or Cramer’s V statistic. The combined results of these tests along with the inferences derived are given in the following table.

Table 1: Results of Tests of Independence of the Groups for Various Socio-Demographic Variables

Socio demographic Variables/	Chi square statistics/ Cramer’s V statistic	P value	Inference
Gender	0.000	1.000	Independent
Religion	0.045	0.978	Independent
Family type	0.041	0.980	Independent
Residence	0.022	0.881	Independent
Status of house	0.163	0.922	Independent
Staying with Parents/Relatives/Hostel ^a	0.017 ^a	0.904	Independent
Father’s Occupation ^a	0.031 ^a	0.955	Independent
Monthly family income	0.274	0.965	Independent
Mother’s Occupation ^a	0.039 ^a	0.896	Independent

Table 1 show that the two characteristics namely the group and the socio-demographic variable are independent of each other. Hence we can conclude that there is homogeneity between the two groups for every socio-demographic variable.

Table 2: Results of Tests of Independence of the Groups With Respect to the Lifestyle of the Respondents

Variable/Characteristic	Chi Square Statistics/ Cramer’s V Statistic	P Value	Inference
Distance of the school from home	0.093	0.993	Independent
Mode of Travel	0,087	0.993	Independent
Access to visit public library	0.000	1.000	Independent
Participation in sports/extracurricular activities	0.022	0.881	Independent
Holidays: Going to movie	0.009	0.923	Independent
Watching TV	0.006	0.937	Independent
Listening to radio	0.111	0.739	Independent
Meeting the relatives	0.174	0.677	Independent
Meeting the friends	0.202	0.709	Independent
Spent time after school hours: Relax for sometimes then reading or doing home assignments	0.006	0.939	Independent
Attending tuition	0.007	0.933	Independent
Doing household work	0.199	0.655	Independent
Spending time with friends	0.073	0.788	Independent
Hobbies: Listening to music	0.030	0.863	Independent
Reading novels	0.000	1.000	Independent
Reading news paper	0.019	0.890	Independent
Playing sports / games	0.022	0.881	Independent

Practicing yoga / meditation	0.000	1.000	Independent
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From Table 2 it can be noticed that all the P values are greater than 0.05, implying that groups are independent of the lifestyle of the respondents.

Table 3: Results of Tests of Independence of the Groups for the Facilities and Issues in the Campus

Variable/Characteristic	Chi Square Statistics/ Cramer's V Statistic	P Value	Inference
Infrastructure and Facilities in the school: Clean campus with good atmosphere	0.570	0.450	Independent
Student friendly class rooms	0.380	0.537	Independent
Spacious and good play ground	0.015	.681	Independent
Mentoring / counseling facility	0.097	0.756	Independent
Clean toilets / rest rooms	0.423	0.516	Independent
Issues and problems faced in the campus: Substance abuse / alcohol dependence	0.000	1.000	Independent
Misuse of Media	0.000	1.000	Independent
Unhealthy friend ships	0.000	1.000	Independent
Peer pressure (Gossiping / mental torturing/ egoism)	0.273	0.601	Independent

The results displayed in Table 3 shows that there is no association between the two characteristics, the groups, and the facilities and issues on the campus.

Table 4: Results of tests of Independence of the Groups for the Family Function Assessment

Variable/Characteristic	Chi Square Statistics/ Cramer's V Statistic	P Value	Inference
Communication system in your family ^a	0.053 ^a	0.570	Independent
There is alcoholism in the family	0.015	0.993	Independent
Understanding between the family members	0.003	0.993	Independent
Domestic violence in the family	0.046	0.997	Independent
There are conflicts in the family	0.000	1.000	Independent
Satisfied with the home atmosphere ^a	0.053 ^a	0.566	Independent
Leisure time activities	0.307	0.858	Independent
Believe in God	2.759	0.097	Independent
Frequency of going to church / temple / mosque	0.006	0.997	Independent
Involvement in the peer group ^a	0.014 ^a	0.929	Independent

a – Cramer's V statistic is used

The results displayed in Table 4 have all P values greater than 0.05, the level of significance. Hence it indicates that there is no significant association between the groups and the family function indicators.

From Tables 1, 2, 3 and 4, it can be concluded that the two groups are not associated with any other factors like socio-demographic characteristics, lifestyle of the respondents, facilities and issues in the campus or family function indicators. i.e. the groups are not influenced by these characteristics. Hence it may be concluded that the two groups are homogeneous. I.e. they are equal in these characteristics. Also, the equality of the average age of the respondents in the two groups was tested using the independent samples t -test at 5% level. The results are given in the following table:

Table 5: Results of Tests of Independence of the Age of the Respondents

Group	Mean (SD)	T	P Value
Control	16.528 (0.606)	1.231	0.219
Intervention	16.475 (0.543)		

The P value obtained is 0.219, which shows that there is no significant difference in the mean age of the respondents between the two groups. This is obvious because the respondents selected are in the range of 16 to 19 years.

Analysis Part 2

A comparative study needs homogeneity of the characteristic under study between the two groups, namely, control group and intervention group) in the baseline level. Independent samples t-test was performed to compare the equality of baseline scores of various components of the mental health status (i.e. somatic symptom, anxiety symptom, social dysfunction, and severe depression) and mental well-being scores for the two groups and the results displayed in the following tables:

Table 6: Results of Independent Sample T -Test for Baseline Scores in General

Component	Group	Mean	T	P-Value
Somatic Symptoms	Control	7.0444	-0.860	0.390
	Intervention	7.2722		
Anxiety Symptoms	Control	7.1194	-0.440	0.660
	Intervention	7.2361		
Social Dysfunction	Control	7.7972	-1.742	0.082
	Intervention	8.2222		
Severe Depression	Control	7.1694	-0.878	0.380
	Intervention	7.4472		
Mental Health Status	Control	29.1306	-1.248	0.212
	Intervention	30.1778		
Mental Well-being	Control	43.2639	-1.111	0.267
	Intervention	43.9028		

The level of significance was fixed at 5%. The null hypothesis tested states that the average baseline scores are equal for the two groups, control, and intervention. The P values in the last column exceed the level of significance 0.05, resulting in the conclusion that the average baseline scores are not significantly different for the two groups under study.

Analysis Based on the Standard Tools Such as GHQ 28 and WEMWBS

Repeated Measures Analysis of Variance (RMANOVA) was performed to test whether there is any significant effect due to intervention in the scores of three-time lines (pre-intervention, post- intervention, and follow-up intervention).

i.e., the total scores of Mental Health Status (Somatic Symptoms, Anxiety Symptoms, Social Dysfunction, and Severe Depression) and the score of Mental Well-being.

Mental Health Status Score (GHQ -28)

Somatic symptom score, Anxiety symptom score, Social dysfunction score, and Severe depression score: GHQ-28- Likerts' scoring (0, 1, 2, 3) was used here. (In the case of mental health status- higher the score means more severe the condition. But in mental well being - higher the score means better the condition).

RMANOVA for Somatic Symptoms

Table 7: Results of RMANOVA for Somatic Symptom Scores

Group	Mean (Standard Deviation)			F Statistic and p Value		
	Pre-Intervention	Post-Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	7.044 (3.413)	6.953 (3.305)	6.906 (3.238)	F=953.79 Df=(2, 1436) P=0.000	F=35.860 DF=(1, 718) P=0.000	F=895.627 DF=(2,1436) P=0.000
Intervention	7.272 (3.688)	3.250 (2.593)	6.069 (3.483)			

The above tables describe the extent of change in the somatic symptom scores among the respondents across the time period of pre-intervention (baseline score), post-intervention, and follow-up intervention, between the two groups control and intervention. Higher scores represent a greater level of somatic symptom. Since p-value is less than 0.05 for the main effect Somatic symptom level over different time periods, we conclude that there is a significant difference in the overall mean score of Somatic symptom in two groups due to intervention. Also, the results tabulated shows that there is a significant difference between the two groups because the p values are less than 0.05 for the between effect 'Group'. There was a highly significant intervention effect between the scores of Somatic symptom over different time periods and the groups, with the value of p=0.000 for the data obtained.

The above table explains that there is a significant difference in the means of Somatic symptom scores over baseline (pr-intervention), post-intervention and follow-up periods. The p-value is less than 0.05, leading to the conclusion that there is a significant effect in Somatic symptom scores due to intervention. i.e., intervention is effective. This is reflected in the score of post-intervention. It can be noticed that the average score is in its maximum at the pre-intervention (baseline), then reduced to a minimum after the post-intervention but increased again in the follow-up intervention level (i.e., higher the score severe the problem). This shows that the intervention is effective among the respondents over a short period of time whereas its impact has reduced as the days go by. The result demands the periodical intervention on the respondents failing which the scores will again increase.

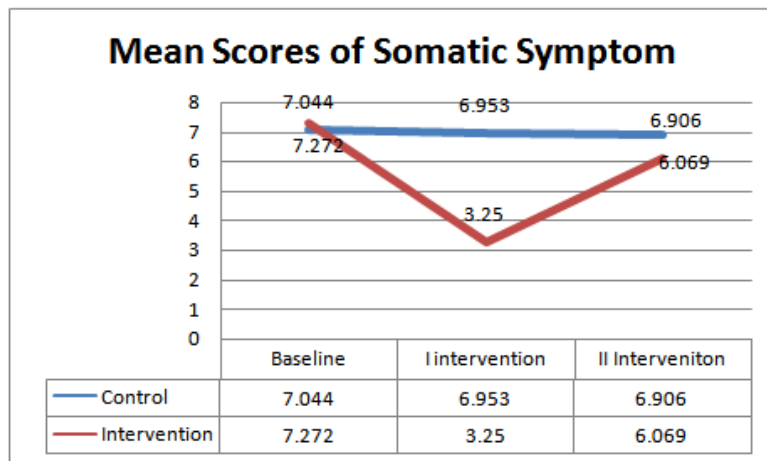


Figure 4: Differences in the Average Scores of the Two Groups

The above line chart shows that the differences in the average scores are more for intervention group whereas for the control group they are not.

RMANOVA for Anxiety Symptoms

Table 8: Results of RMANOVA for Anxiety Symptom Scores

Group	Mean (Standard Deviation)			F Statistic and p Value		
	Pre-Int.	post-Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	7.119 (3.403)	7.019 (3.330)	6.986 (3.276)	F=838.789 Df=(2, 1436) P=0.000	F=40.851 DF=(1, 718) P=0.000	F=776.733 DF=(2,1436) P=0.000
Intervention	7.236 (3.702)	3.291 (2.602)	5.997 (3.451)			

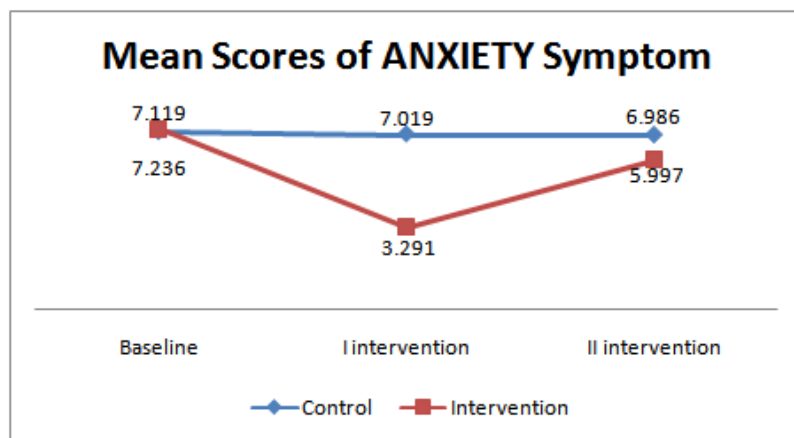


Figure 5: Mean Scores of Anxiety Symptom

The above line chart shows that the differences in the average scores are more for intervention group whereas for the control group they are not.

RMANOVA for Social Dysfunction

Table 9: Results of RMANOVA for Social Dysfunction Scores

Group	Mean (Standard Deviation)			F statistic and p value		
	Baseline /Pre-Test	Post Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	7.797 (3.185)	7.739 (3.136)	7.717 (3.110)	F=1268.661 Df=(2, 1436) P=0.000	F=44.629 DF=(1, 718) P=0.000	F=1229.444 DF=(2,1436) P=0.000
Intervention	8.222 (3.358)	3.439 (2.820)	7.053 (3.178)			

The above table describes the extent of change in the Social Dysfunction scores among the respondents across the time period of pre – intervention (baseline), after post - intervention and after follow - up intervention, between the two groups control and intervention. Higher scores represent a greater level of Social Dysfunction. Since p-value is less than 0.05 for the main effect Social Dysfunction level over different time periods, we conclude that there is a significant difference in the overall mean score of Social Dysfunction in two groups due to intervention.

Also, the results tabulated shows that there is a significant difference between the two groups because the p values are less than 0.05 for the between effect 'Group'. There was a highly significant interaction effect between the scores of Social Dysfunction over different time periods and the groups, with the value of p=0.000 for the data obtained.

The above table explains that there is a significant difference in the means of Social Dysfunction scores over pre-test (baseline), post-intervention and follow-up intervention periods. The p-value is less than 0.05, leading to the conclusion that there is a significant effect in Social Dysfunction scores due to intervention. i.e, intervention is effective. This is reflected in the score of post-intervention. It can be noticed that the average score is in its maximum at the baseline, then reduced to a minimum after the post-intervention but increased again in the follow-up intervention level. This emphasizes the need for continuous/periodic intervention for the respondents.

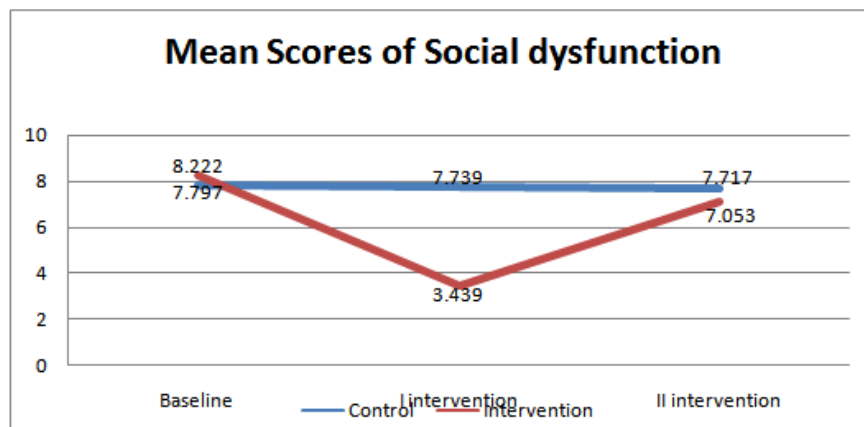


Figure 6: Mean Score of Social Dysfunction

The above line chart shows that the differences in the average scores are more for intervention group whereas for the control group they are not.

RMANOVA for Severe Depression

Table 10: Results of RMANOVA for Severe Depression Scores

Group	Mean (Standard Deviation)			F statistic and p Value		
	Baseline / Pre-Int.	Post-Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	7.169 (4.155)	7.092 (4.061)	7.056 (4.016)	F=611.993 Df=(2, 1436) P=0.000	F=20.549 DF=(1, 718) P=0.000	F=573.261 DF=(2,1436) P=0.000
Intervention	7.447 (4.336)	3.758 (3.102)	6.175 (4.053)			

The above table describes the extent of change in the Severe Depression scores among the respondents across the time period of pre-intervention (baseline), post-intervention and follow-up intervention, between the two groups control and intervention. Higher scores represent a greater level of Depression.

Since p-value is less than 0.05 for the main effect Severe Depression level over different time periods, we conclude that there is a significant difference in the overall mean score of Severe Depression in two groups due to intervention. Also, the results tabulated shows that there is a significant difference between the two groups because the p values are less than 0.05 for the between effect ‘Group’.

There was a highly significant interaction effect between the scores of Severe Depression over different time periods and the groups, with the value of p=0.000 for the data obtained. Since the interaction effect between the scores of Severe Depression differed significantly. The above table explains that there is a significant difference in the means of Severe Depression scores over pre-intervention (baseline),post-intervention and follow-up intervention periods. The p-value is less than 0.05, leading to the conclusion that there is a significant effect in Severe Depression scores due to intervention. i.e., intervention is effective.

This is reflected in the score of post-intervention. It can be noticed that the average score is in its maximum at the baseline, then reduced to a minimum after the post-intervention but increased again in the follow-up intervention level. This emphasizes the need for continuous/periodic intervention for the respondents.

The line chart given below shows that the differences in the average scores are more for intervention group whereas for the control group they are not.

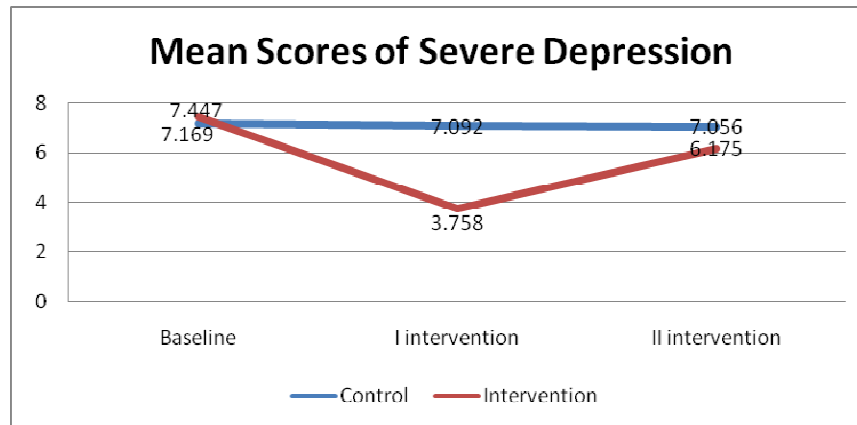


Figure 7: Mean Score of Severe Depression

RMANOVA for Total Score of Mental Health Status

Table 11: Results of RMANOVA for Total Mental Health Status Scores

Group	Mean (Standard Deviation)			F Statistic and p Value		
	Baseline /Pre-Int.	Post-Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	29.131 (10.752)	28.803 (10.461)	28.664 (10.298)	F=1438.067 Df=(2, 1436) P=0.000	F=56.891 DF=(1, 718) P=0.000	F=1358.828 DF=(2,1436) P=0.000
Intervention	30.178 (11.739)	13.739 (9.126)	25.294 (11.052)			

The above table describes the extent of change in the Total Mental Health Status scores among the respondents across the time period of Pre-intervention (baseline), post-intervention and follow-up intervention, between the two groups control and intervention. Higher scores represent a lower level of Mental Health Status.

Since p-value is less than 0.05 for the main effect Total Mental Health Status score over different time periods, we conclude that there is a significant difference in the overall mean score of Total Mental Health status scores in two groups due to intervention. Also, the results tabulated shows that there is a significant difference between the two groups because the p values are less than 0.05 for the between effect 'Group'. There was a highly significant interaction effect

between the scores of Total Mental Health Status over different time periods and the groups, with the value of $p=0.000$ for the data obtained.

The above table explains that there is a significant difference in the means of Total Mental Health Status scores over pre-intervention (baseline), post-intervention and follow-up intervention periods. The p -value is less than 0.05, leading to the conclusion that there is a significant effect in Total Mental Health Status scores due to intervention. i.e., intervention is effective. This is reflected in the score of post- intervention. It can be noticed that the average score is in its maximum at the baseline, then reduced to a minimum after the post-intervention but increased again in the follow-up intervention level. This emphasizes the need for continuous/periodic intervention for the respondents.

The line chart given below shows that the differences in the average scores are more for intervention group whereas for the control group they are not.

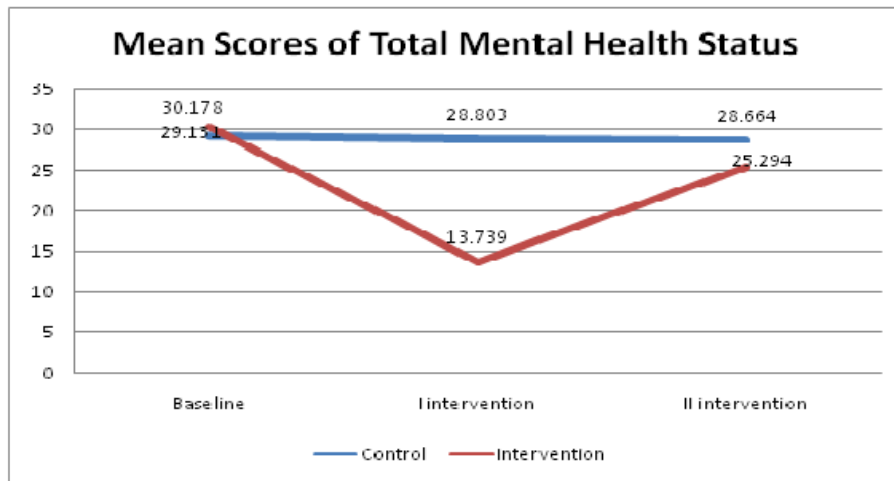


Figure 8: Mean Score of Total Mental Health Status

RMANOVA for Mental Well Being

Table 12: Results of RMANOVA for Mental Wellbeing Scores

Group	Mean (Standard Deviation)			F Statistic and p Value		
	Baseline /Pre-int.	Post- Intervention	Follow-up Intervention	Time	Group	Time*Group Interaction
Control	43.269 (7.453)	43.533 (7.128)	43.633 (6.927)	F=1435.309 Df=(2, 1436) P=0.000	F=90.403 DF=(1, 718) P=0.000	F=1354.173 DF=(2,1436) P=0.000
Intervention	43.903 (7.975)	55.067 (5.990)	46.300 (7.503)			

The above table describes the extent of change in the mental wellbeing scores among the respondents across the time period of pre-intervention (baseline), post-intervention and follow-up intervention, between the two groups control and intervention. Higher scores represent a higher level of mental wellbeing.

Since p -value is less than 0.05 for the main effect mental wellbeing level over different time periods, we conclude that there is a significant difference in the overall mean score of mental wellbeing in two groups due to intervention. Also,

the results tabulated shows that there is a significant difference between the two groups because the p values are less than 0.05 for the between effect 'Group'. There was a highly significant interaction effect between the scores of Mental wellbeing over different time periods and the groups, with the value of $p=0.000$ for the data obtained.

The above table explains that there is a significant difference in the means of mental wellbeing scores over pre-intervention (baseline), post-intervention and follow-up intervention periods. The p-value is less than 0.05, leading to the conclusion that there is a significant effect in mental wellbeing scores due to intervention. i.e., intervention is effective. This is reflected in the score of post-intervention. It can be noticed that the average score is in its minimum at the baseline, then increased to maximum in the post-intervention but decreased again in the follow-up intervention level (Higher the score, better the condition). This emphasizes the need for continuous/periodic intervention for the respondents.

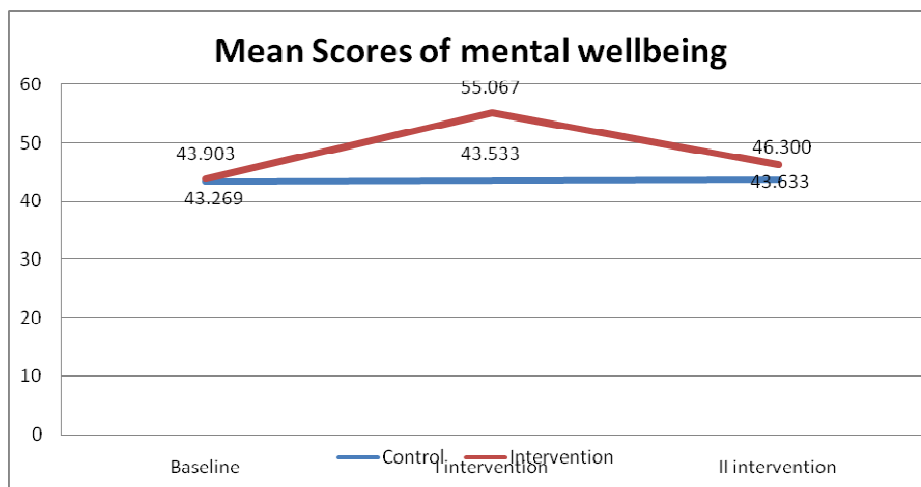


Figure 8: Mean Score of Mental Wellbeing

The above line chart shows that the differences in the average scores are more for intervention group whereas for the control group they are not, (higher the score means, better the condition) i.e., intervention is effective.

Effect of Intervention on Mental Health Status and Mental Well Being of the Respondents

The effect of an intervention on the respondents is proven through the RMANOVA procedure. Following table shows the percentage of respondents whose mental health has improved after the intervention.

Table 13: The Effect of Intervention – Percentage of Improvement of the Respondents

Components	Status	Group	
		Control	Intervention
Somatic Symptom	Deteriorated	0.3	0.0
	Remained the same	91.9	0.8
	Improved	7.8	99.2
Anxiety Symptom	Deteriorated	0.0	0.3
	Remained the same	91.9	0.8
	Improved	8.1	98.9
Social Dysfunction	Deteriorated	0.0	0.3
	Remained the same	95.3	0.6
	Improved	4.7	99.1
Severe Depression	Deteriorated	1.4	0.0
	Remained the same	90.6	1.7
	Improved	8.0	98.3

Mental Health Status	Deteriorated	1.7	0.0
	Remained the same	76.4	0.0
	Improved	21.9	100.0
Mental well being	Deteriorated	0.0	0.6
	Remained the same	83.9	0.3
	Improved	16.1	99.1

The above table explains the effect of the intervention tested by the RMANOVA procedure, and the result shows that there was a highly significant intervention effect between the scores of mental health status and well being. The researcher has noticed that a tremendous number of respondents - i.e., 100 % of respondents in mental health status group and 99.1% of respondents in mental well being group - were benefitted by the intervention program.

The correlation between the scores of two questionnaires namely, the mental health status questionnaire and the mental well-being questionnaires are significantly negatively correlated at 0.01 level of significance, which is, of course, the desired result. When the scores of the first mental health questionnaire are higher, the scores of mental well-being questionnaire are expected to be less. The results of the same are given in the following table.

Table 14

Mental Capital / Mental Health Status	Mental Well-Being		
	Base Line / Pre-Intervention	Post- Intervention	Follow-up Intervention
Base Line/ Pre-intervention	-0.418		
Post- intervention		-0.663	
Follow-up			-0.422

CONCLUSIONS

As per the result of this study, it is very clear that there is a highly significant intervention effect between the scores of the two groups. In the case of mental health status score, it can be noticed that the average score is in its maximum at the baseline (pre-intervention level), then reduced to a minimum at the post-intervention but increased again in the follow-intervention level (i.e. Lower the score, better the condition). But in the case of mental wellbeing a score, it is reflected that the average score is in its minimum at the baseline (pre-intervention level), then increased to maximum in the post-intervention but decreased again in the follow-up intervention level (i.e. Higher the score, better the condition). This emphasizes the need for continuous/periodic intervention for the respondents. Hence, it is concluded that life skills training program in the school setting is effective for enhancing mental health status and well being of young people.

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