Measuring the Quality of Life and Mental Well-being of Adolescents in Urban Resettlements: Implications for Social Work Research

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ABSTRACT:

Background: Measuring quality of life (QOL) is a means to achieve the goal of any scholastic or social action.

Methods: A descriptive cross-sectional design was adopted, and multistage hybrid sampling was used to recruit 301 participants from the urban resettlements in Chennai, India.

Results: Study findings showed that adolescents' QOL was very poor in five key indicators, i.e., extreme amount of financial difficulties (86%), not at all feeling safe and secure (63%), not at all liking the lived environment (58%), feeling very unhappy about relationships within family (42%), and always experiencing negative feelings (84%). The self-reported symptoms of mental health problems included insomnia (43%), depression (16%), anxiety (5%), and suicidal ideation (11%). A measurement of mental well-being showed that 93% experienced the worst possible mental well-being and only 7% had the best possible mental well-being.

Conclusion: Against this backdrop, a comprehensive measurement of QOL is needed in social work, assessing both the objective and subjective aspects of living conditions and individuals' perceptions of their lived realities.

Keywords: Quality of Life, Mental Well-being, Mental Health, Social Work, Adolescents, Social Work Research, Sustainable Development Goals.

Introduction

Quality of Life (QOL) denotes an all-encompassing concept inclusive of healthcare aspects and the most essential elements of life, that altogether enable the overall well-being of individuals and their satisfaction with life (Willis et al., 2021). The measurement of QOL is based on the lived experiences and outlooks of the individual, guaranteeing that the decision about what a meaningful life looks like emerges from the particular individual being studied (Smythe et al., 2026). The quality of life in urban regions includes material and non-material conditions, individual and shared life conditions, the objective aspects of these conditions (based on universal metrics) and the subjective aspects (individual satisfaction) (Wesz et al., 2023). In the urban context, assessing QOL and well-being of children and adolescents requires a multi-faceted, mixed methods approach, viz., one that mirrors what matters most in the child or adolescent's own words (Willis et al., 2021).

The World Health Organization (WHO) defines adolescence as a transitional phase between 10 to 19 years, starting with physiological development and culminating with an improved sense of self, individual identity and behaviour (World Health Organization, 2017). A study among adolescents during the recent Covid-19 pandemic showed that a greater sense of coherence (SOC) and optimism were linked to improved health-related quality of life (HRQOL) levels (Tal-Saban & Zaguri-Vittenberg, 2022). Measuring urban QOL among adolescents and young adults necessitates a concurrent assessment of three important components, viz. objective living conditions, individual satisfaction and the significance of such living conditions in their lives. Towards this end, there are seven dimensions to urban QOL, viz., services, economic background, culture and recreation, mobility, conviviality, safety and a comfortable environment (Wesz et al., 2023).

In the context of adolescents and young adults with chronic health conditions, almost half of them experienced moderate to severe impact on HRQOL (Wang et al., 2023). A study showed that the HRQOL of children and adolescents declined during the Covid-19 pandemic, and emotional problems, mental health issues, anxiety, depression and psychosomatic symptoms were on the rise. In particular, socially disadvantaged children and adolescents were at significant risk of mental health problems. During this phase, positive family and social support sustained the mental health of such children and adolescents.

According to Orban et al. (2024), children and adolescents experienced a sharp rise in mental health problems, particularly anxiety and depression, during the pandemic period. There was also a decline in their HRQOL during the pandemic, and this did not subside when the lockdowns ended. In this regard, it is important to raise awareness of resilience factors, viz., sense of coherence (SOC) and hope among adolescents so as to strengthen their resolve and safeguard their mental health during challenging life conditions (Tal-Saban & Zaguri-Vittenberg, 2022). Another study by Mikkelsen et al. (2022) showed that there was a substantial decline in adolescents' HRQOL in terms of physical and psychological well-being between 14 to 16 years. In this context, stress, loneliness and pain were found to have a significant negative impact on HRQOL, while self-esteem and self-efficacy had a positive impact.

Measuring adolescents' quality of life is a means to achieve the goal of any scholastic or social action aimed at enhancing inclusion by helping adolescents channelise their lives towards continuous improvement in all aspects of importance. Such an enhancement is facilitated when QOL is placed at the core of educational processes (Losada-Puente et al., 2020). Against this backdrop, health promotion, prevention and intervention strategies can help children and adolescents cope with challenging life conditions while maintaining their mental health (Ravens-Sieberer et al., 2023). In the emerging healthcare landscape, social workers contribute as case managers, coordinators, evaluators, therapists and researchers, helping to enhance the quality of life of the most vulnerable populations (Auslander, 2014). The measurement of adolescents' QOL should offer a comprehensive perspective by conducting an integrated assessment of both the objective and subjective aspects of their lived realities, across the numerous dimensions or areas of significance to them (Losada-Puente et al., 2020). Addressing this research gap, the current study aims to shed light on the quality of life and mental health of adolescents in the urban resettlements in Chennai and, in so doing, provide implications for social work research in comprehensively measuring QOL of the most vulnerable populations.

Methods

A total of 301 participants were recruited from the urban resettlements in Chennai, India. The study used a descriptive cross-sectional design and multistage hybrid sampling, whereby in the first stage, five settlements (n=5) were randomly selected from among 203 urban housing tenements maintained by the Tamil Nadu Urban Habitat

Development Board (TNUHDB, 2026). Subsequently, in the second stage, participants were selected using simple random sampling. The sample size of the population (n=33,893) was calculated using Cochran's formula,

$$n_0 = (Z^2 * p * (1-p)) / e^2$$

Where n_0 was the desired sample size, Z the confidence interval (CI=1.96; 95%), p the estimated proportion of the population (set at 0.5 for maximum variability and adequate sample size), and e the margin of error with 6% prevalence. The sample size calculated was n=265. In order to ensure adequate sampling representativeness of this vulnerable population, targeted oversampling was done, and the final sample size was n=301. The sample size in each settlement was determined based on the number of households.

A pretested, pilot-tested, validated and ethically approved semi-structured interview questionnaire was used to collect data. The inclusion criteria were individuals aged 10 to 19 years, residing in the settlement for a period of not less than one year, and resettled from within Chennai city. Data collection was done between May 2025 and January 2026. The questionnaire comprised three domains, viz., socio-demography, quality of life (QOL), and mental well-being. The socio-demographic variables provided information on adolescents (age, sex, education attained) and their parents (education, occupation, monthly family income and house ownership). WHOQOL (World Health Organization, 2012) constituted five sub-domains, i.e., financial difficulties, safe and secure environment, extent of liking the lived environment, relationship with family members and frequency of negative feelings (despair, anxiety and depression). Mental health comprised self-reported symptoms of mental health problems, loss of sleep, hypervigilance, low self-esteem, persistent feeling of sadness, depression, anxiety, despair and suicidal ideation.

The WHO-5 Well-being Index (World Health Organization, 2024), a self-reported generic measure of worst possible mental well-being (n=0) or best possible mental well-being (n=25) was rated by participants. The scale consists of five items rating participants' feelings on a 6-point scale ranging from 0 ("at no time) to 5 ("all the time"). The five items were feeling cheerful and in good spirits, feeling calm and relaxed, feeling active and vigorous, feeling fresh and rested and daily life filled with things that interest. The items were then reversed, raw scores summed (0 to 25) and transformed to a percentage score ranging from 0 to 100.

Ethical approval was obtained from the Institutional Ethics Committee (IEC), and based on the recommendations, a random selection of samples was undertaken through in-person interviews with participants. In order to obtain parental consent, the researcher contacted families of adolescents (<18 years) in the urban resettlements who expressed an interest in participating in the study. Both the parents and participants received a clear orientation about the study purpose, i.e., measuring quality of life and mental well-being. Only participants and parents (for those <18 years) who provided informed consent were included in the study. Statistical analysis was performed using IBM SPSS Version 21. Chi-square and one-way ANOVA tests were conducted to determine significant associations between variables.

The study strictly adhered to the 2024 Declaration of Helsinki (The World Medical Association, 2024) in promoting and ensuring respect for all participants and protecting their health and rights. A significant limitation was sampling representativeness (n=301), given the importance of measuring the QOL and mental well-being of a high-risk vulnerable population. However, this was addressed by adopting multi-stage random sampling to increase the generalizability of study findings. Any future research, if undertaken, can increase sample representativeness through targeted oversampling of such marginalized populations.

Results

Table I: Socio-demography

Variables	Attributes	N (%)
Age (Years)	10 to 14	55 (18)
	15 to 19	246 (82)
Sex	Male	294 (97)
	Female	6 (2)
	Transgender	1 (1)
Education Attained	Illiterate	1 (1)
	Primary school	5 (2)

	Middle school	91 (30)
	Secondary school	131 (43)
	Higher secondary school	36 (12)
	Under Graduation	37 (12)
Education of Family Head	Illiterate	127 (42)
	Primary school	72 (24)
	Middle school	41 (14)
	Secondary school	43 (14)
	Higher secondary school	9 (3)
	Under Graduation	9 (3)
Occupation of Family Head	Unemployed	84 (28)
	Skilled	121 (40)
	Un-skilled	53 (18)
	Semi-skilled	37 (12)
	Professional	6 (2)
Monthly Family Income (₹)	7,988 or below	10 (3)
	7,989 to 23,869	179 (60)
	23,870 to 39,829	100 (33)
	39,830 to 59,794	12 (4)
House Ownership	Own	219 (73)
	Rental	82 (27)

97% of participants were male, aged 15 to 19 years (82%) (Late-adolescence), while 1% was transgender. 43% attained secondary school education, 30% attained middle school, whereas only 12% attained higher secondary education. In terms of the education of the family head, 42% were illiterate, 24% attained primary school, and only 3% attained higher secondary school education. Further, with regard to the occupation of the family head, 40% were engaged in skilled work, 28% were unemployed, 18% were engaged in unskilled informal labour, and only 2% were employed in professional occupations. The monthly family income classified based on the modified Kuppuswamy socio-economic status (SES) scale (Mandal & Hossain, 2025) showed that 60% reported a monthly income between Rs. 7,989 and 23,869, 33% reported an income between Rs. 23,870 and 39,829, while 3% reported an income of Rs. 7,988 or below. 73% lived in their own housing tenement allotted by the Tamil Nadu Urban Habitat Development Board (TNUHDB, 2026).

The World Health Organization QOL scale (WHOQOL) (World Health Organization, 2012) was adopted to measure the QOL of participants. Study findings showed that on a 5-point scale (1 denoting 'not at all' to 5 denoting extremely), 86% participants reported an extreme amount of financial difficulty in the family, 4% reported a moderate amount, and only 1% reported not having financial difficulties. 63% reported not at all feeling safe and secure in the urban resettlement, 22% reported feeling slightly safe, and 13% reported feeling moderately safe, while only 2% reported feeling very safe in the resettlement. 58% reported not at all liking their residence in the resettlement, 23% reported liking a little, 12% liked it to a moderate amount, and only 7% liked it very much. 42% participants reported feeling very unhappy within their family, 15 % were unhappy, 15% were neither happy nor unhappy, 26% were happy, and only 2% were very happy. 84% participants reported experiencing negative feelings, i.e., despair, anxiety and depression, all the time, 6 % reported very often; 4% reported quite often; and only 2% reported never having negative feelings.

Table II: Quality of Life (QOL) of Adolescents

Variables	Attributes	N (%)	QOL * Education P<0.05
Extent of liking residence in the resettlement	Not at all	174 (58)	0.01**
	A little	69 (23)	
	A moderate amount	36 (12)	

	Very much	22 (7)	
	An extreme amount	0 (0)	
Feeling happy about relationship with family	Very unhappy	127 (42)	0.04*
	Unhappy	46 (15)	
	Neither happy nor unhappy	46 (15)	
	Happy	77 (26)	
	Very happy	5 (2)	
Extent of financial difficulties in family	Not at all	3 (1)	0.976
	A little	8 (2)	
	A moderate amount	13 (4)	
	Very much	16 (5)	
	An extreme amount	260 (86)	
	Don't know	1 (1)	
Feeling safe and secure	Not at all	189 (63)	0.282
	Slightly	67 (22)	
	Moderately	38 (13)	
	Very much	7 (2)	
	Extremely	0 (0)	
Frequency of negative feelings such as despair, anxiety and depression	Never	6 (2)	0.998
	Seldom	12 (4)	
	Quite often	12 (4)	
	Very often	19 (6)	
	Always	252 (84)	

A chi-square test showed that there was a significant association between the extent of liking the place of residence and education attained (0.01**). Likewise, the extent of feeling happy about family relationships was significantly associated with education attained (0.04*). Concerning self-reported symptoms of mental health problems, 43% reported insomnia, 14% experienced hypervigilance, 16% reported depression, 5% had anxiety disorder, 11% reported suicidal ideations, and a significant 10% experienced all the above symptoms.

Table III: Self-reported Mental Health Symptoms

Self-reported Mental Health Symptoms	N (%)
Insomnia	131 (43)
Hypervigilance	42 (14)
Depression	47 (16)
Anxiety	14 (5)
Despair	1 (1)
Suicidal ideations	35 (11)
All the above	31 (10)
	301 (100)

In terms of mental well-being, 70% reported never feeling cheerful and in good spirits at any point in time, 22% felt cheerful some of the time, and only 1% felt cheerful all the time. Likewise, 64% reported never feeling calm and relaxed at any point in time, 27% reported feeling calm some of the time, while only 5%

reported feeling calm most of the time. 47% participants never felt active and vigorous at any point in time, 29% felt active some of the time, while only 5% felt active all the time. 68% of participants never woke up feeling fresh and rested at any point in time, 17% felt fresh and rested some of the time, while only 5% felt fresh and rested all the time. 79% of participants reported that their daily life was never filled with things that interested them at any point in time, 12% reported some of the time, while only 1% reported that they had it all the time.

Table IV: WHO-5 Mental Well-being Index

Variables	Attributes	Scale (0 to 5)	N (%)
I have felt cheerful and in good sprits	All the time	5	1 (1)
	Most of the time	4	12 (4)
	More than half the time	3	9 (3)
	Less than half the time	2	3 (1)
	Some of the time	1	65 (22)
	At no time	0	211 (70)
I have felt calm and relaxed	All the time	5	0 (0)
	Most of the time	4	15 (5)
	More than half the time	3	10 (3)
	Less than half the time	2	3 (1)
	Some of the time	1	82 (27)
	At no time	0	191 (64)
I have felt active and vigorous	All the time	5	16 (5)
	Most of the time	4	28 (9)
	More than half the time	3	20 (7)
	Less than half the time	2	9 (3)
	Some of the time	1	86 (29)
	At no time	0	142 (47)
I woke up feeling fresh and rested	All the time	5	16 (5)
	Most of the time	4	20 (6)
	More than half the time	3	8 (3)
	Less than half the time	2	2 (1)
	Some of the time	1	51 (17)
	At no time	0	204 (68)
My daily life has been filled with things that interest me	All the time	5	1 (1)
	Most of the time	4	14 (5)
	More than half the time	3	8 (2)
	Less than half the time	2	1 (1)
	Some of the time	1	38 (12)
	At no time	0	239 (79)

Measuring the scores of participants on a 6-point scale (0 to 5), with raw score calculated individually by summing the scale value for all five variables (0 to 25), it was found that 93% participants were below the cut-off value (n=13) thus indicating worst possible mental well-being. Among the study participants, 24% participants had the lowest mental well-being score of '0' and only 1% had the highest score (n=21) indicating best possible mental well-being.

Table V: WHO-5 Mental Well-being Measurement among Adolescents

Mental Well-being Raw Score (0 - 25)	Percentage Score (0 – 100)	N (%)	Scale Interpretation	Mental Well-being
0	0	73 (24)	Worst Possible Mental Well-being	0
1	4	65 (22)		
2	8	25 (8)		
3	12	37 (12)		

4	16	18 (6)		
5	20	13 (4)		
6	24	20 (7)		
7	28	8 (3)		
8	32	8 (3)		
9	36	4 (1)		
10	40	4 (1)		
11	44	3 (1)		
12	48	3 (1)		
13	52	4 (1)		
14	56	6 (2)		
15	60	3 (1)		
16	64	3 (1)		
17	68	3 (1)		
21	84	1 (1)	Best Possible Mental Well-being	100
N < 25	N < 100	301 (100)	* A percentage score below 50 (or raw score below 13) is the cut-off for poor mental well-being and is an indication for further assessment for the possible presence of a mental health conditions (World Health Organization, 2024).	

The findings of the mental well-being index showed that the data had a high amount of variation and was widely distributed (SD=4.164) around the mean (n=3.49). This indicated that the well-being scores differed drastically from one another. Further the high standard deviation (SD) implied that the data was highly skewed, contained extreme outliers and had a huge cluster of zero score or lowest possible score values. Further this showed that the mean (n=3.49) was not a representation of a typical participant, since individual scores fluctuated heavily.

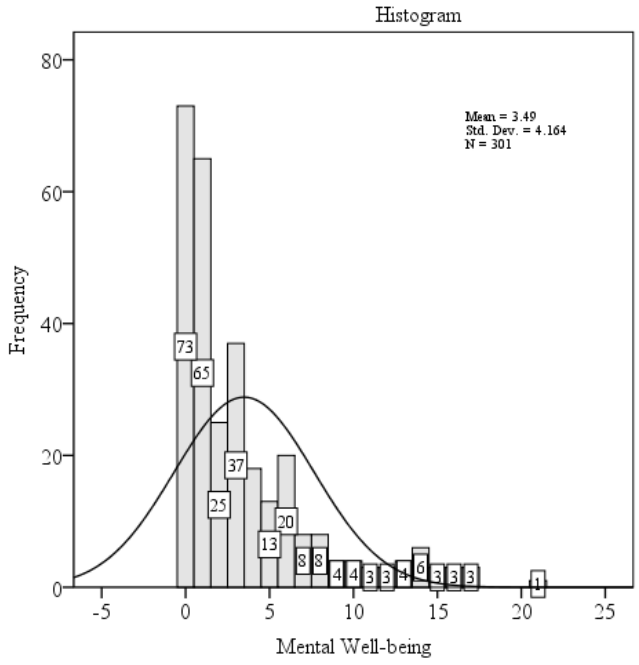

Figure I: Histogram – Mental Well-being of the Sample

A one-way ANOVA showed that, the extent of financial difficulties in the family was significantly

associated with feeling safe and secure (p=0.004**), feeling happy about relationships within the family (p=0.05*) and frequency of negative feelings (despair, anxiety and depression) among study participants (p=0.001**). Likewise there was a significant association between the extent of feeling safe and secure and self-reported symptoms of mental health problems (p=0.05**) and there was a significant association between extent of feeling happy about family relationships and symptoms of mental health problems experienced (p=0.003**).

Discussion

This study is the first to the best of our knowledge that has measured mental well-being and QOL of adolescents in the urban resettlements in Chennai, India and provided implications for social work research. Study findings showed that, in terms of SES, majority 60% participants reported a lower monthly family income between Rs. 7,989 and 23,869. Administering the WHOQOL instrument (World Health Organization, 2012), study findings showed that QOL of adolescents was very low in five key indicators, viz., extreme amount of financial difficulties (86%), not at all feeling safe and secure (63%), not at all liking the lived environment (58%), feeling very unhappy about family relationships (42%) and experiencing negative feelings always (84%). A study by (Nutakor et al., 2023) showed that SES was a robust indicator of QOL and there was a positive correlation between QOL and social capital. Therefore in order to improve QOL, it is vital to create and foster social networks, community linkages, enhance social capital among individuals and guarantee equitable access to resources and opportunities.

With regard to self-reported symptoms of mental health problems, participants reported insomnia (43%), depression (16%), anxiety (5%), suicidal ideations (11%) and a combination of multiple symptoms (10%). In this context, strengthening adolescents' self-esteem and self-belief through individual therapy and working closely with systems and support agents in their lived environment was crucial to promote resilience among them (Sulimani-Aidan, 2018). There is a need to ensure social support networks, facilitate social care, provide social skill trainings and undertake innovative approaches beyond social support so to enhance QOL (Singstad et al., 2021). A study by (Swerts et al., 2023) among adolescents in care settings, emphasized the need for more qualitative research in order to acquire an in-depth understanding about how adolescents construct and realize QOL.

In terms of mental well-being, based on WHO-5 Mental Well-being score, 93% participants experienced the worst possible mental well-being (24% scoring '0') and only 7% had the best possible mental well-being. Social work has widely been recognized as a profession grounded in furthering individual well-being and helping cater to the basic needs of all people, with a particular attention to marginalized, vulnerable and below poverty line populations (Garkisch & Goldkind, 2025). In this context, conversation analysis (CA) is a qualitative research method in social work that provides rigorous data for studying real-time challenges and prospects for professional interventions (Flinkfeldt et al., 2022). Another approach is the constructivist grounded theory (CGT) method in social work research. CGT is closely aligned with the theories of social work in studying the individual in the context of their surrounding environment. This approach emphasizes the importance of respecting and valuing the individual, viewing their perspectives as unique and significant (Clarke et al., 2023).

A study by (Ide & Beddoe, 2024) explored a reflexive approach in social work research through reflection viz., questioning, analyzing and evaluating oneself in all stages of research. This involves reflecting on one's own thinking, observing emotions and thought processes, establishing role boundaries, understanding power dynamics in relationship with participants and exploring the perceived lived experiences of vulnerable individuals. Similarly, critical race theory (CRT) a theoretical framework in undertaking social work research is also significant while studying vulnerable populations. The framework amplifies the voices and perspectives of the voiceless, and inspires the research problem to be seen from a social, political and historical perspective (Daftary, 2020).

A reflexive approach in social work examines the findings through analyzing the knowledge process of the researcher, while also questioning the lived experiences of participants using the researcher's own words in presenting others' perceptions and experiences (Ide & Beddoe, 2024). Participatory research is yet another approach for the social work profession to work collaboratively with service users in undertaking research activities (Flanagan, 2020). In the current age of artificial intelligence (AI) driven research, an integrated model of AI-enhanced social work research has been proposed, combining social work methods and AI tools (Garkisch & Goldkind, 2025).

Conclusion

The study showed that adolescents experienced

poor quality of life, primarily attributable to financial difficulties, negative emotional experiences, lack of safety, and strained family relationships. Mental health concerns were also prevalent, as reflected in reported symptoms of depression, anxiety, suicidal ideation, and sleep disturbances. These findings underscore the need for a holistic approach to the assessment of QOL and mental well-being, integrating both measurable indicators and individuals' lived experiences and perspectives. Such an approach can enable healthcare providers, including professional social workers, to identify unmet care needs, facilitate more empathetic and informed shared decision-making, and strengthen interventions for vulnerable populations. Future research should further advance the conceptualization, measurement, and assessment of QOL and mental well-being within social work research, with particular emphasis on vulnerable and marginalised populations.

Statements and Declarations

Author contributions: Study conception, material preparation, data collection, data curation, formal analysis, interpretation and writing of the original draft were done by the first author with the guidance of second author. The second author did the review and editing. All the authors have read and agreed to the final version of the manuscript.

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Ethical considerations: The study was conducted in adherence to the 2024 Declaration of Helsinki (DOH) and granted ethical clearance by the Institutional Ethics Committee (IEC No.9101, 21.05.2025).

Informed consent statement: Informed consent was obtained from all participants involved in the study and their parents (for <18 years).

Data availability statement: The data supporting the findings of the current study are not publicly available due to participants' privacy. However, the anonymized data may be made available by the corresponding author on reasonable request.

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Conflicts of Interest: The authors declare no conflict of interest.

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