Trinity College Dublin
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VISTA

SCOPE for HEALTH: Integrating mental and sexual healthcare for young people with anxiety and/or depression: Insights from the Growing up In Ireland Child Cohort

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Project website: https://vista-apro.eu/
Funder: Health Research Board
Meeting: Growing Up in Ireland conference, November 2026

Background

- Recent report in *the Lancet* highlights rates mental health difficulties (MHD), particularly depression and anxiety, has grown significantly among those aged 10-24 since 1990[1]

- MHD treatment can contribute to early onset of chronic diseases (e.g., premature cardiovascular disease)[2]

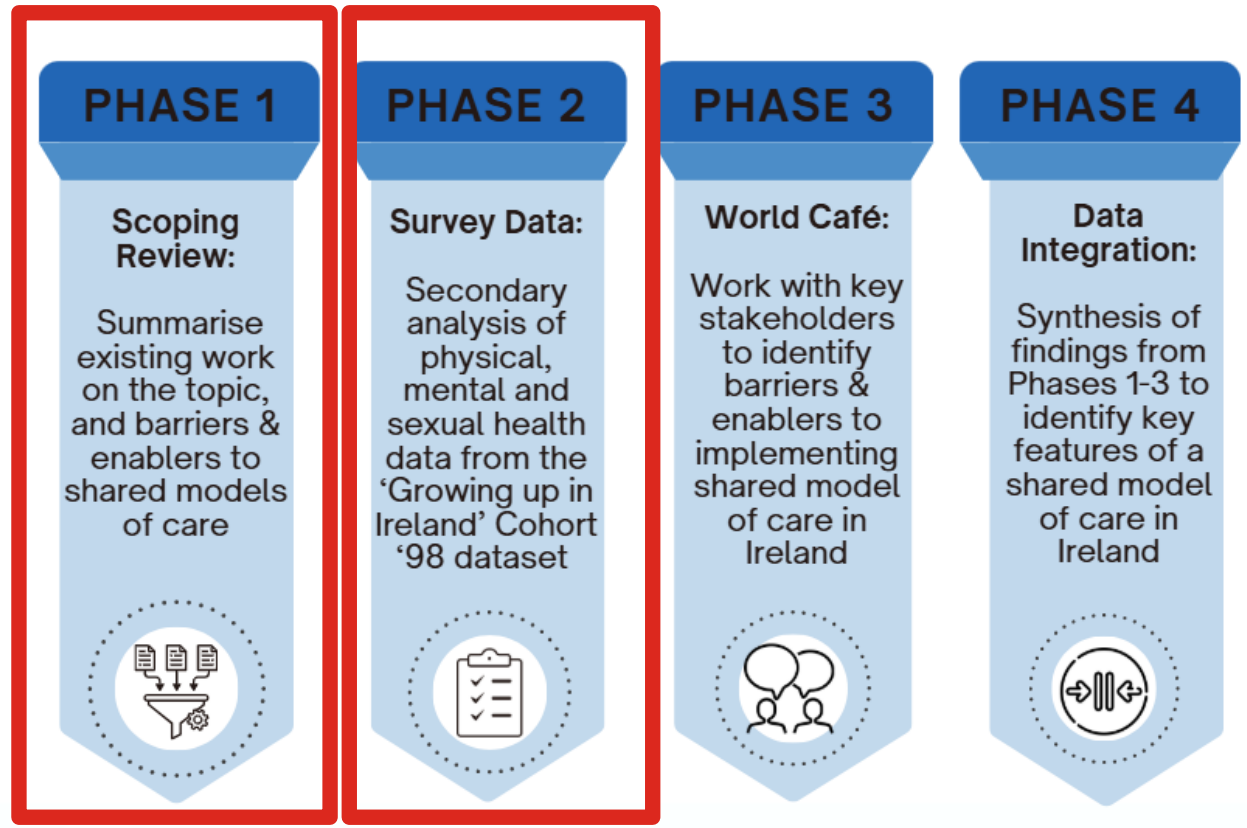
- Sexual behaviours of young people with MHD
    - 2.28 times more likely to contract STIs compared to peers (95%CI: 2.02 – 2.57; $p < 0.05$)[3]
    - 1.34 more likely to experience an unplanned pregnancy compared to those without MHD (95%CI: 1.08 – 1.67)[4]

- *Sharing the Vision*- Recommendation 19 for shared care *(physical health not actually sexual health!)*



Background

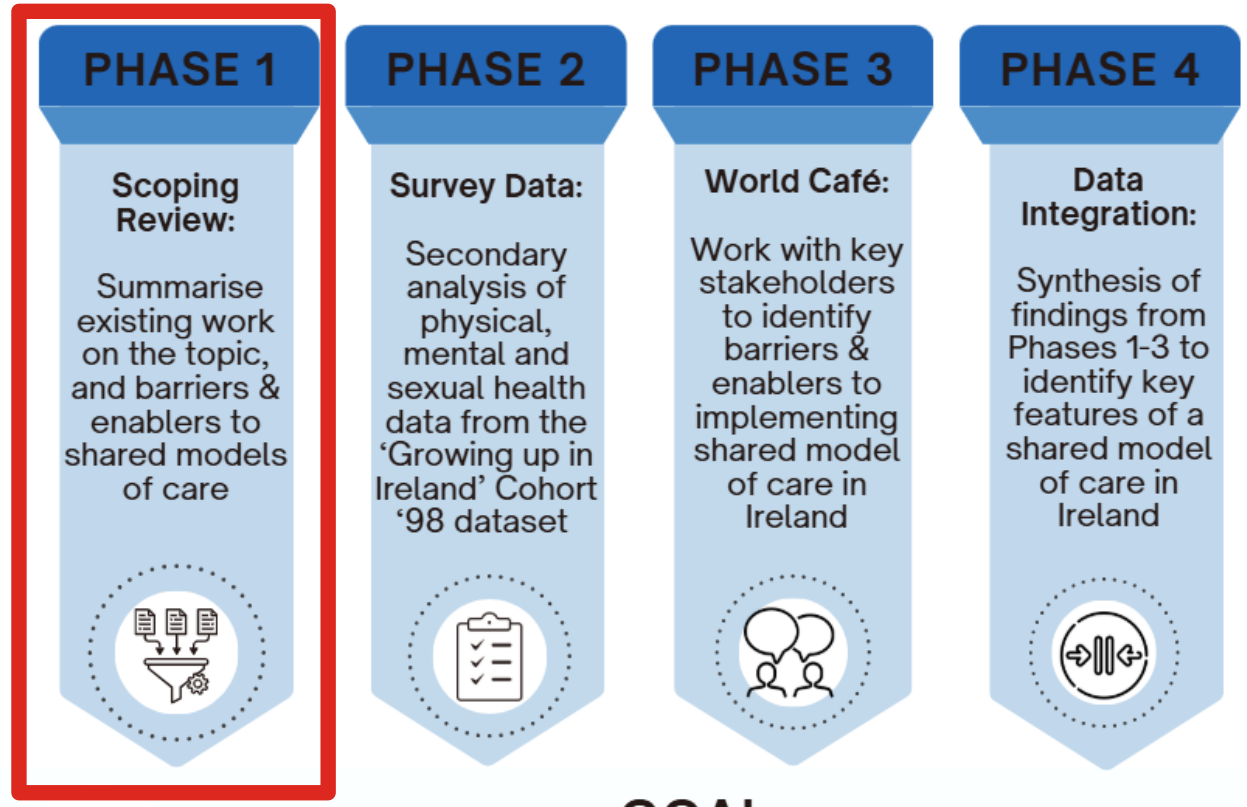
- Shared Model Of Care (SMOC) recommended in Ireland's national mental health policies for over a decade, but has yet to be implemented
- SCOPE for HEALTH seeks to action this recommendation using implementation science and active PPI engagement
- Goal to develop a SMOC that is evidence-based, realistic and meaningful to young service users, healthcare providers and service managers in Ireland.



Scoping Review Aims

1) To identify and characterise SMOC which integrate physical and/or sexual healthcare for young people with mental health difficulties

2) To synthesise implementation barriers and enablers using the Implementation Science based Consolidated Framework for Implementation Research (CFIR)



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BMC Health Services Research

SYSTEMATIC REVIEW Open Access

Implementing shared care models for young people with mental health difficulties: a consolidated framework for implementation research- informed scoping review of service integration across physical, sexual and mental health domains

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Barriers

- Staff turnover (n=9)
- Societal mental health stigma (n=7)
- Funding models (n=6)
- Limited time with patients (n=5)

Enablers

- Inclusive models of care (n=7)
- Clear & consistent communication across settings (n=5)
- Protected training time (n=4)
- Building on existing partnerships (n=3)

Reflection on Findings from PPI Team Members

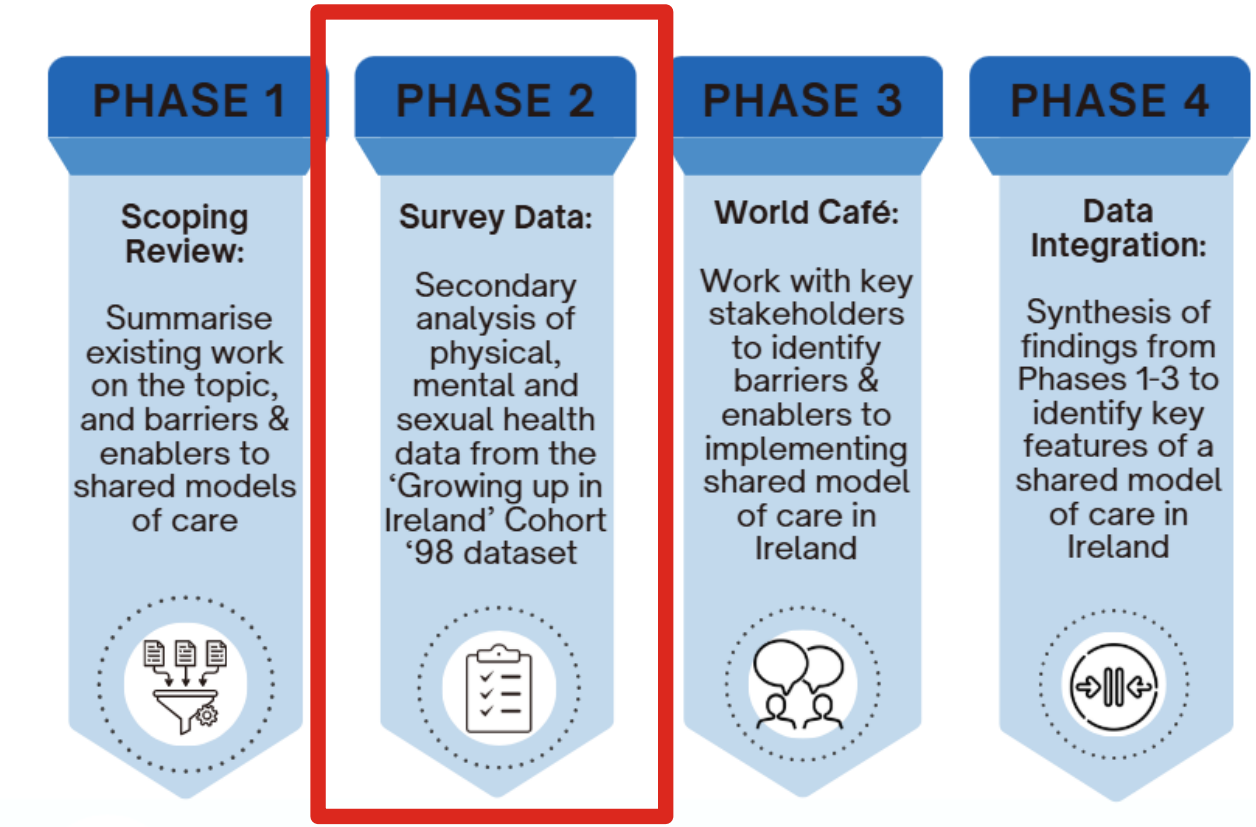
"The scoping review offers scaffolding on which to build a shared model of care and highlights the (felt) need for better sexual health and wellbeing support. The "shared" aspect doesn't just refer to more integrated, cohesive care, but that support is also shared across physical, sexual, and mental health needs. A co-created, adaptable, de-stigmatising model, founded on good communication, is crucial to delivering effective care." - Patient Partner

"The sexual health of young people with existing mental health diagnoses is often sidelined by the 'bigger' problem, creating a dangerous vacuum, leaving the people we love at risk. This paper convincingly highlights why we can't kick the can down the road." - Public Partner

Growing up in Ireland Aims:

Objective:

To examine associations between self-reported anxiety and/or depression (A/D) diagnosis and sexual health and wellbeing at ages 17/18, 20 and 25.



Methods:

Study Population: Youth participants in the GUI Child Cohort '98 dataset

Wave 1: aged 9 (n=8568)

Wave 2: aged 13 (n=7525)

Wave 3: aged 17/18 (n=6216)

Wave 4: aged 20 (n=5190)

Wave 5: aged 25 (n= 2849)

Focus of our analyses

Methods: Anxiety and/or depression (A/D)

Analysis	Definition
At each age/wave	Self-reported **ever received a** diagnosis
Consistent history reported at all three waves	"Yes" at all of the three waves
No reported diagnosis	"No" at all three waves

Question: "Have you ***ever*** been diagnosed with depression or anxiety by a doctor/psychologist/psychiatrist?"

Methods:

Independent Variables: mapped available proxy measures to Mitchell et al. (2021)

- # sexual partners, STI history, contraception use
- Biological sex, gender identity, sexual orientation
- Sense of coercion from partners/peers,

reflecting on timing of first sexual activity

- Romantic relationship status & quality

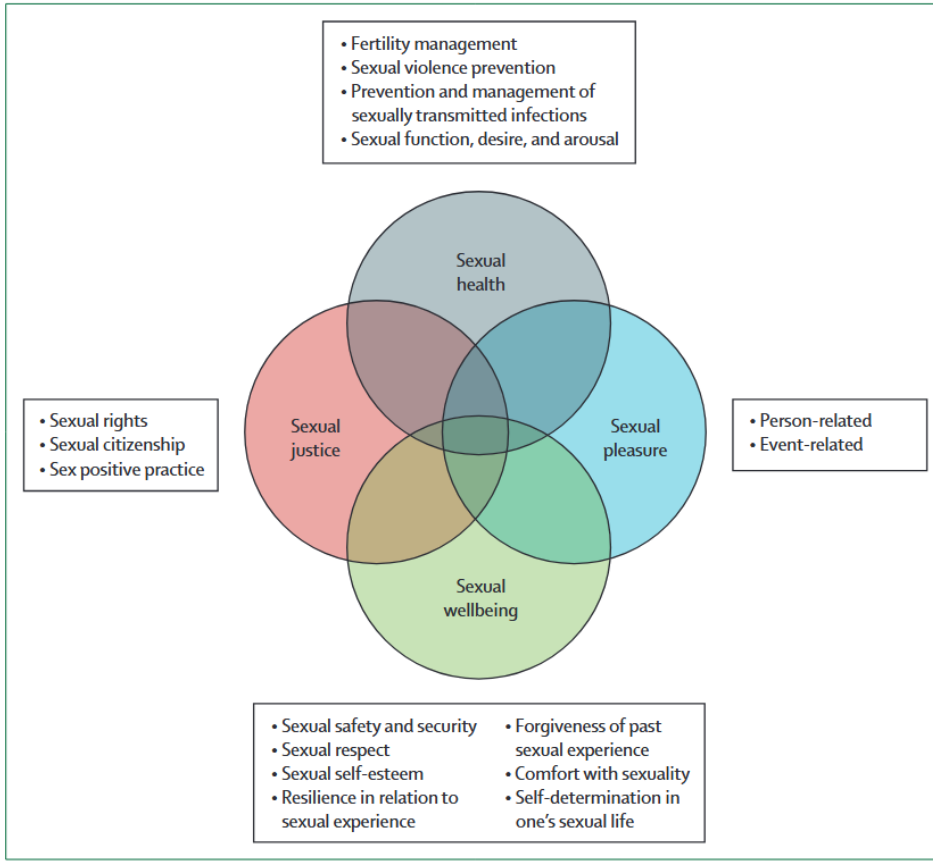


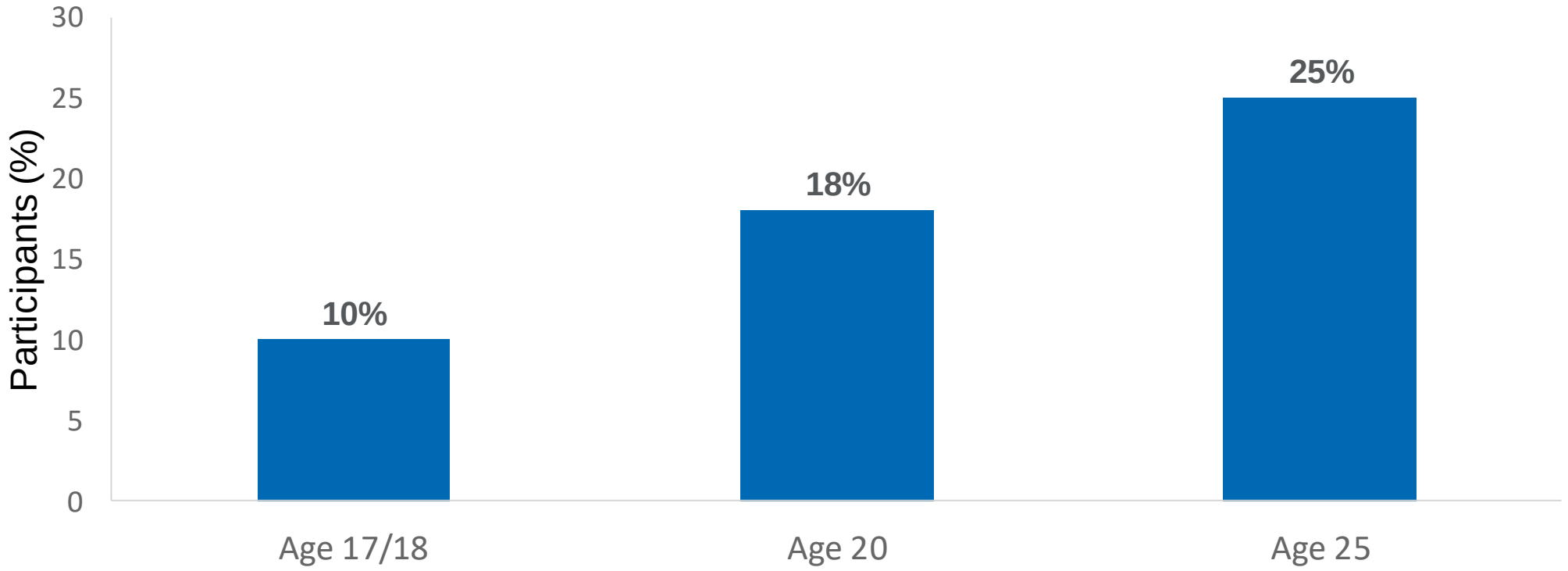
Figure: **Four pillars of comprehensive public health focused inquiry and intervention in relation to sexuality**

Data Analysis:

- Weighted descriptive analyses and multivariable logistic regression at each age.

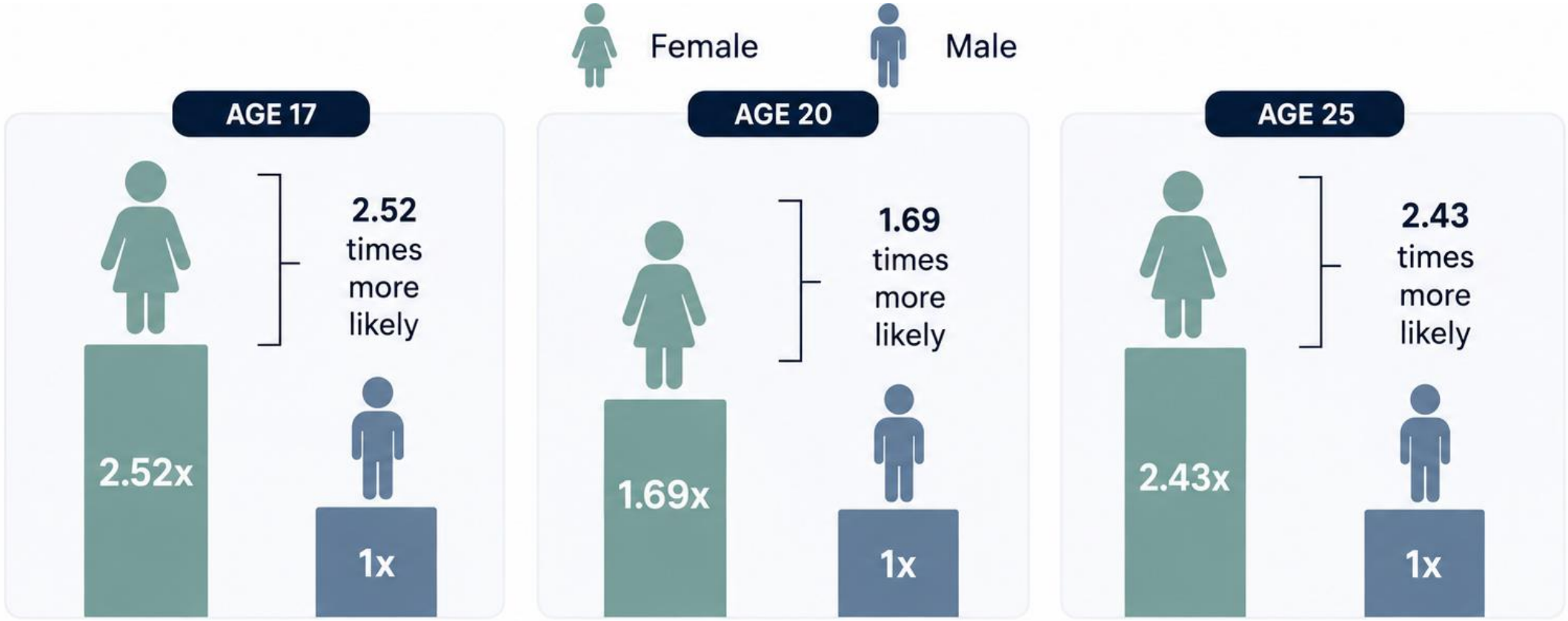
- Additional analysis compared participants *consistently reporting* an A/D diagnosis history at all three waves with those reporting no diagnosis at any wave.

Reported (self-reported) diagnosis increased across waves



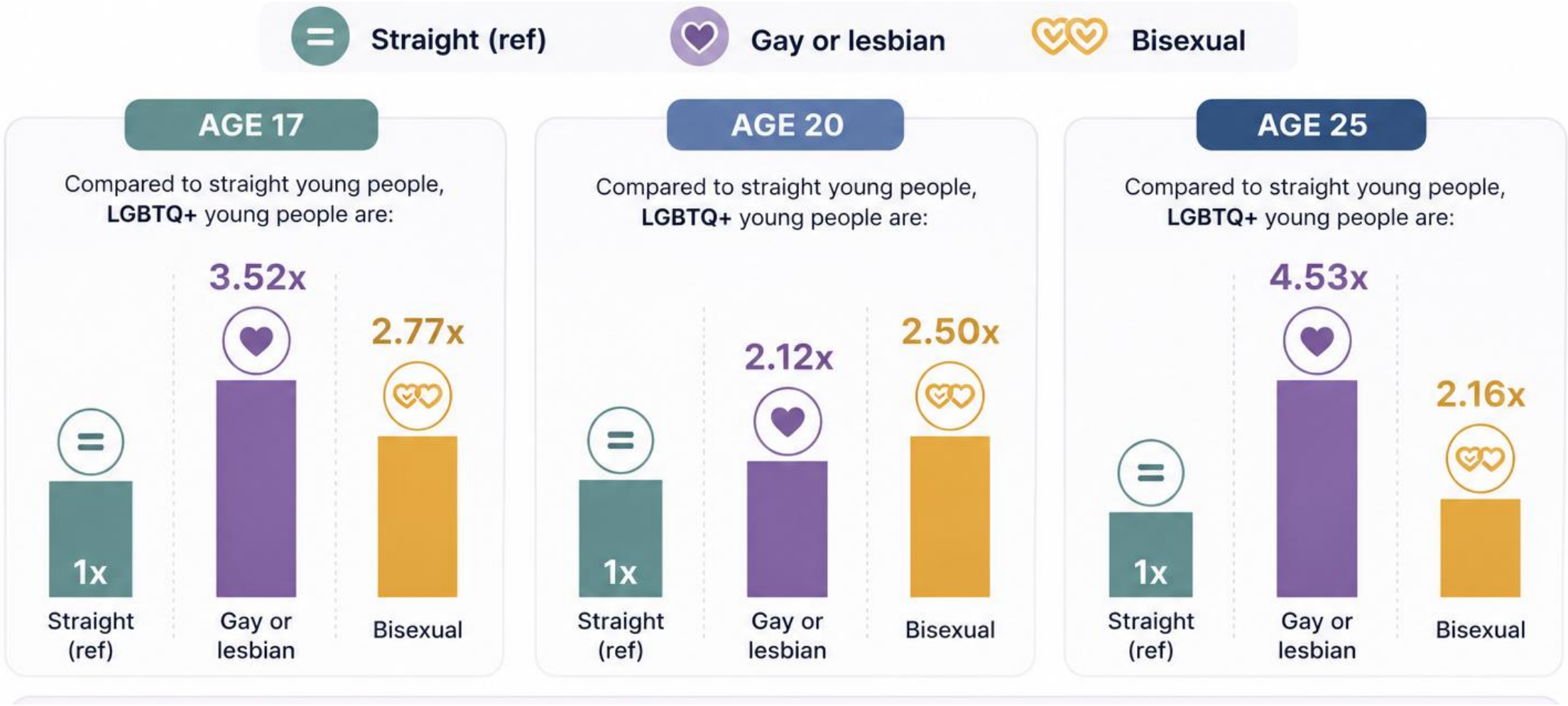
10%, 18% and 25% reported an ever-diagnosis. These are wave-specific estimates.

Results: Biological Sex



Cross sectional

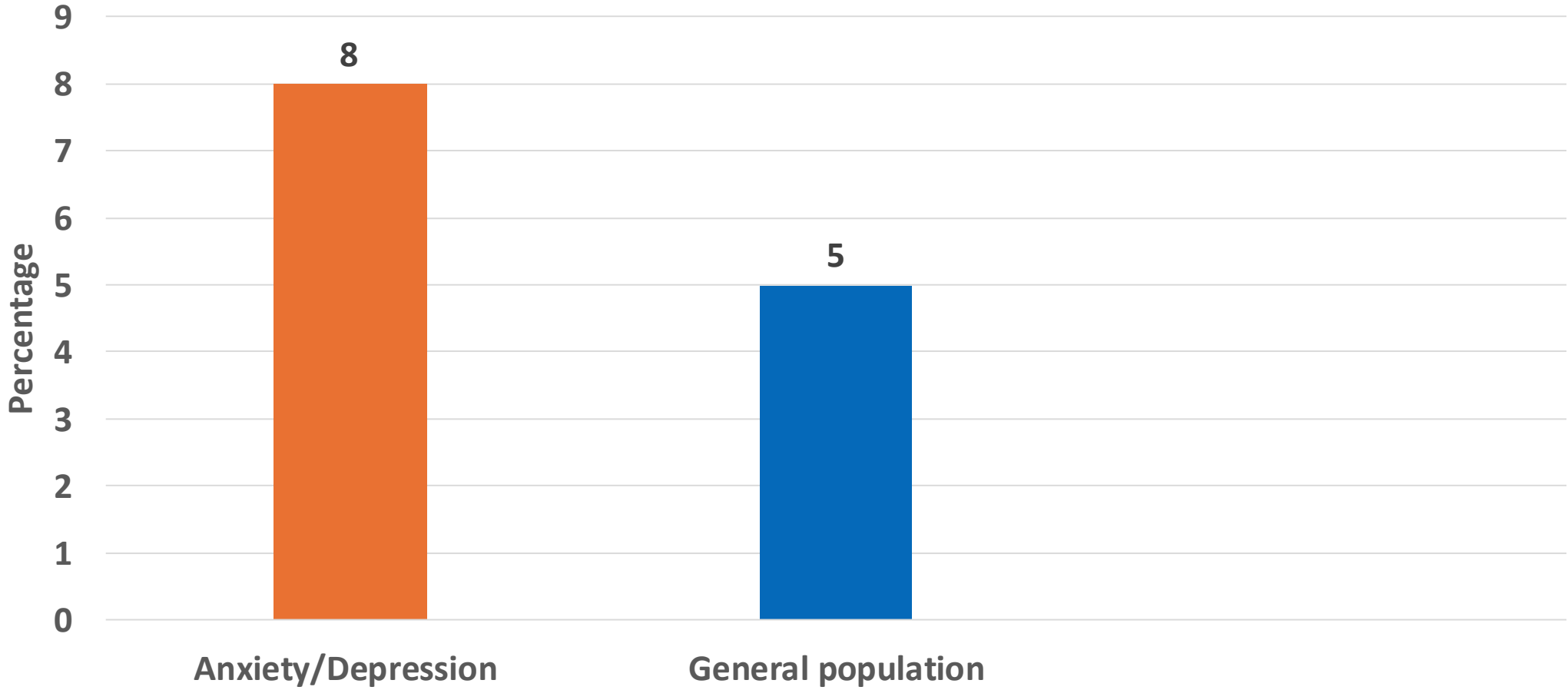
Results: Sexual orientation



Cross sectional

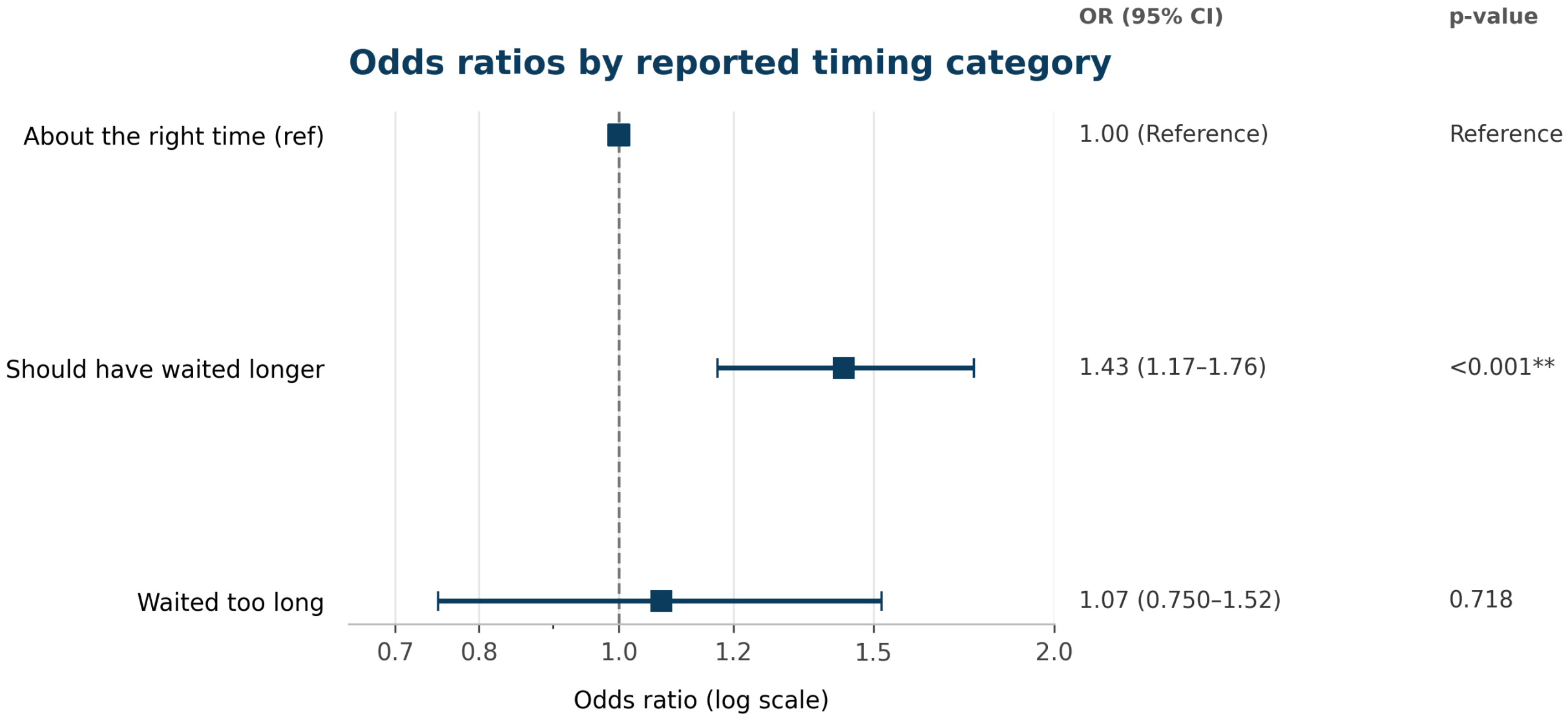
Results: Reflection on Sexual Activity

Were you ever afraid of losing a boyfriend/girlfriend by not having sex? (age 17)



** p <0.01

Results: Reflection on Sexual Activity (age 20)



Results:
Sexual experiences and contraception (age 20)

Comparison	Adjusted OR (95% CI)
Nearly always uses contraception vs always	1.01(0.61–0.92)
Sometimes uses contraception (50%) vs always	1.42* (1.08–1.86)
Rarely/Never uses contraception (25%) vs always	1.56* (1.14–2.14)

* p <0.05

Outcome: self-reported A/D diagnosis. Findings support attention to readiness and contraception needs.

Results: Romantic Relationships (age 25)



Consistent reporting of anxiety and/or depression across all three waves: adjusted associations

Age-25 indicator	OR (95% CI)
Female vs male	4.34*** (2.52–7.46)
Cohabiting/married/engaged vs single	8.80*** (4.49–17.27)
Bisexual vs straight	3.17*** (1.77–5.70)
History of ≥1 STI vs none	3.40*** (1.73–6.71)

*** p <0.001

Interpretation & limitations

- Self-reported data
- Population-level data, not clinical
- Scales used are ***not*** diagnostic; but valid and reliable instruments
- The 'ever diagnosed with anxiety/depression' item cannot establish current illness, symptom persistence or recurrence
- Sexual health measures cover only part of wellbeing, and some wording assumes heterosexual relationships
- Sampling & differential attrition (weighting can only do so much!)
- Very few health system use indicators

Considerations for Shared Model of Care

Staffing:

- GPs & mental health professionals
- Allied health professionals
- Need to prioritise role clarity within models, providers' scopes of practice and information sharing across settings

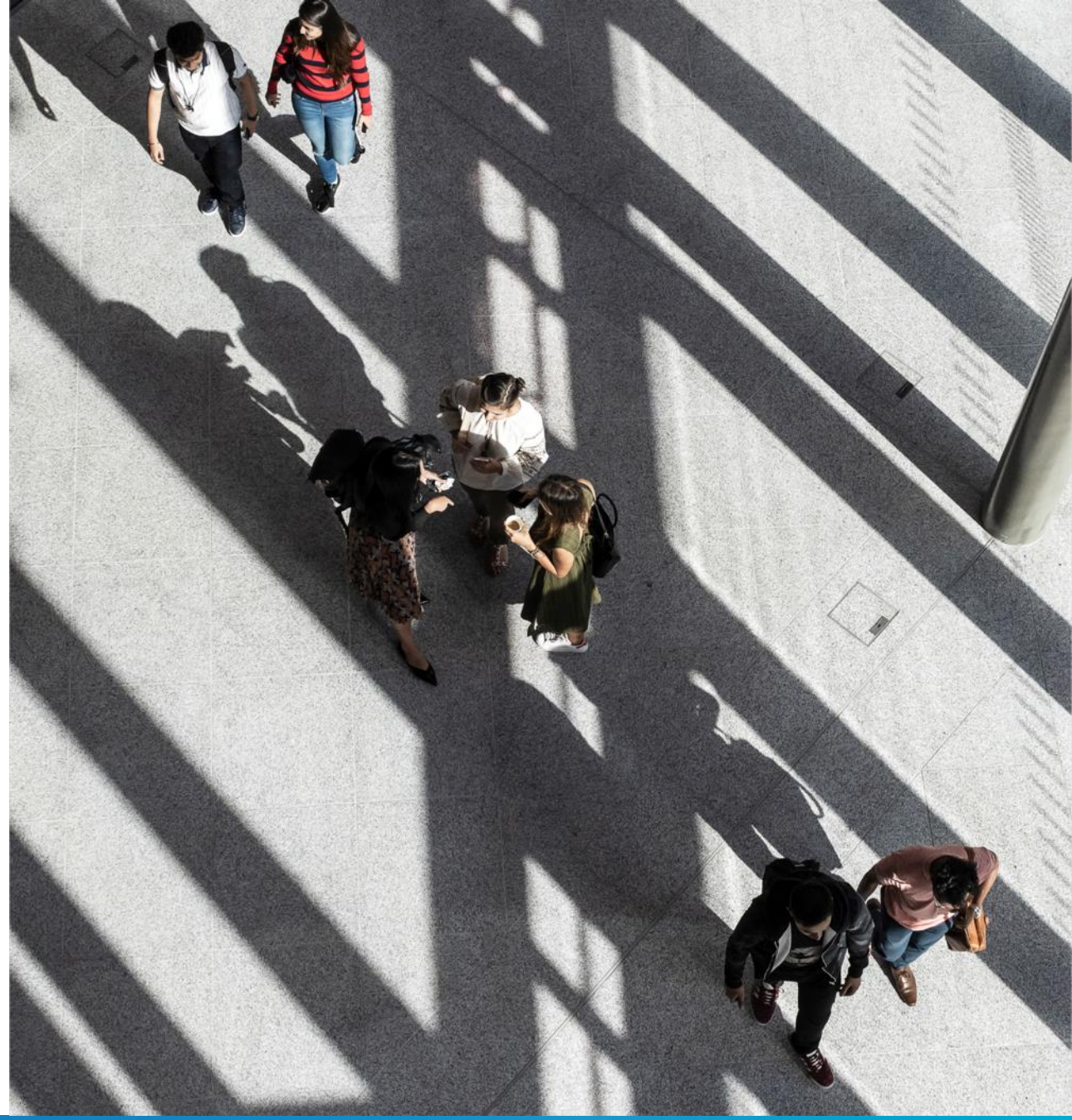
Model components to consider:

- Routine (and sensitive) screening, intervention and ongoing monitoring
- Universal health promotion of healthy sex life and romantic relationships
- Care that recognisies gender + LGBT diversity and specific needs
- Linking primary care, CAMHS, community sexual health services, and digital supports
- Support for contraception, STI prevention and testing alongside readiness, consent and relationship wellbeing.
- Prioritise authentic engagement with young people in SMOC and care planning

Next steps

Contextualise findings in terms of Scoping Review

Findings will help inform prospective qualitative data collection to inform shared model of care blueprint for Ireland



Thank you & happy to answer questions

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