THE CATHOLIC CHURCH
IN THE EUROPEAN UNION

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Reflection Paper

MENTAL HEALTH IN EUROPE

A Call for Care

SQUARE DE MEEÛS 19 – BE-1050 BRUSSELS | TEL. +32 2 235 05 10 | EMAIL: COMECE@COMECE.EU
WWW.COMECE.EU | TWITTER - FACEBOOK - INSTAGRAM: @COMECEEU

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This Reflection Paper was drafted by the COMECE Commission on Ethics as a contribution to the discourse about mental health in the European Union. Its aim is to offer European decision-makers and stakeholders some reflections for orientation and recommendations for concrete action.

I. Executive summary and key recommendations for action

Europe is currently facing a complex and interconnected set of mental health challenges, including depression, anxiety, trauma, social isolation, substance use disorders, the psychosocial effects of migration and digitalization, humanitarian crises, population ageing, precarious employment, and suicide. In response, the European Union and its Member States have expanded and strengthened policy frameworks to promote prevention, early intervention, accessible treatment, and the reduction of stigma surrounding mental illness. Rooted in Christian anthropology, Catholic teaching affirms the inherent dignity, unity, and relational nature of every human person. Mental health is therefore understood not solely as a clinical issue, but as an expression of human vulnerability that calls for compassion, solidarity, and holistic care. By integrating biological, psychological, social, and spiritual dimensions, the Church offers an ethical and human-centred framework that can complement public policy and professional practice. This reflection aims to provide policymakers, practitioners, and stakeholders with insights that support mental well-being while upholding human dignity across Europe.

Mental health and loneliness

- Recognize loneliness as a public mental health priority and include it as a cross-cutting issue across all relevant EU policy areas.
- Strengthening and supporting families as primary communities of care is a strong contribution for improving mental health in the Europe.
- Invest in community-based and faith-informed networks of accompaniment. Active solidarity with those who experience isolation or marginalisation is a social responsibility and a moral imperative.

Mental health and digitalisation

- Digital tools should support — never replace — therapeutic and interpersonal connections, help combat stigma through accurate information and supportive communities, and ensure strict protection of privacy, especially for the most vulnerable.
- Local communities, including parish networks, play a vital role in using technology to reach isolated individuals, with technology serving as a bridge rather than a tool of isolation.
- Digital innovation must be guided by respect for human dignity. The EU must incorporate the risks posed by uncontrolled digitalisation to mental health into EU legislation as a key safeguard of fundamental rights.
- The opportunity to increase digital connectivity between the healthcare systems of EU Member States must be seized in order to improve the data available on the mental health of EU citizens.

Mental health and the specific challenges of women

- Raise awareness for the specific situation of women involved in strong caregiving responsibilities. This important contribution to society must be recognised and actively supported by the EU. Support by legal measures is necessary to ease the challenges.
- EU policy has to include a more holistic approach and human-centred policy approach that recognises the interconnection between physical safety, psychological well-being, and social inclusion of women.

Mental health and humanitarian crisis in the context of migration

- EU policy must encourage early identification of vulnerability and the provision of tailored, multidisciplinary assistance, recognizing that delayed or inadequate intervention can have long-term consequences for mental health and social integration.
- It is crucial to recognizes that refugee mental health cannot be understood solely through a clinical or medical lens. It must be understood within a broader context of social, legal and structural determinants of health. Factors such as stable housing, access to education and employment, family unity, and legal certainty are all crucial for psychological well-being
- Children and adolescents constitute a particularly vulnerable subgroup among the refugee population. Disrupted education, exposure to trauma, family separation, and prolonged uncertainty can significantly affect their mental and emotional development.
- It is important to support linguistic integration of newcomers, and when needed, to include an even stronger promotion into EU policy for the use of cultural mediators and interpreters, as well as community-based approaches and outreach-oriented approaches to improve accessibility and trust in mental health services
- Awareness campaigns about illegal migration risks must be integrated into EU external migration policy.

Mental health and the protection of life

a) Mental health and the ecological crisis

- Address ecological and health crises by recognising the deep interconnections between human health, animal health, plant life, and the natural environment.
- Leaving one's home due to climate-related factors or witnessing the loss of places with deep cultural or spiritual value, can undermine the unity of communities and individuals' sense of identity—two elements that are vital for maintaining psychological well-being.
- Strengthen the link between EU climate protection policy and EU health policy in the context of mental health. Mechanisms and measures should be implemented through educational systems, to reach EU citizens who need ecological education as well as awareness of the importance of mental health.

b) Mental health risks in the context of surrogacy

- Contemporary research in neuroscience and developmental psychology reveals that the maternal-foetal bond is not merely a social or cultural construct but a deeply rooted physiological and biological process.
- From an ethical perspective grounded in the protection of life and the holistic understanding of the human person, strong concerns must be raised about ongoing legal, medical, and policy debates underlined by the call of Pope Francis for a global ban of surrogacy.[1]

c) Mental health in the context of palliative care

- In the context of palliative care, a strong moral commitment is essential protecting life until its natural end, rejecting internal despair and external pressures that might lead individuals to perceive their lives as no longer valuable.
- EU health policy must ensure that healthcare professionals engaged in palliative care can develop a particular responsibility to create a safe space where patients can freely express their fears, doubts and desires.
- Incorporating spiritual care into palliative care is essential for preserving life's dignity in its most fragile form. It offers a comprehensive approach that recognizes the unique needs of everyone, ensuring that no patient is left to suffer in isolation, despair, or a sense of meaninglessness.

II. Introduction

The contemporary world is grappling with a mental health crisis of unprecedented scale and complexity.

Europe today confronts a wide range of interrelated mental health challenges, including depression, anxiety and mood disorders, trauma, social isolation, substance use disorders, the psychosocial effects of migration, digitalization, humanitarian crises, population ageing, precarious working conditions, and suicide. These evolving and intersecting challenges have prompted the European Union and its member states to broaden and strengthen policy frameworks aimed at prevention, early intervention, treatment, and the reduction of stigma associated with mental illness.

The WHO defines mental health as "*a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in..*"[2]

The Council of the European Union, in its conclusions on mental health of November 30, 2023, bases its recommendations to the Commission and Member States on Article 35 of the Charter of Fundamental Rights of the European Union: "*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the*

[1] Pope Francis in his address to members of the Diplomatic Corps accredited to the Holy See, January 8,2024

[2] World Mental Health Report, 2022

conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."[3]From this perspective, care for mental health must move beyond a purely clinical or biomedical approach. It requires attention to the quality of human relationships, the dignity of everyday life, and the conditions that allow individuals to experience belonging, meaning, and purpose. Mental well-being is deeply connected to social inclusion, moral recognition, and the assurance that every person has a place within the community.

Under EU law, mental health is treated as part of public health, and the European Union's competences in this field are supporting, coordinating, and complementary.The key legal basis is Article 168 of the Treaty on the Functioning of the European Union . But it is also important to see, that the EU can adopt binding measures affecting mental health when they are indirectly linked to other areas of exclusive EU competences like the internal market, workplace safety or data protection.

Against this background, the present reflection paper, developed by the Commission on Ethics of COMECE, seeks to explore the contribution of the Catholic Church to contemporary understandings of mental health. It examines how the Church's anthropological and moral framework intersects with current mental health discourse, and how Catholic institutions participate in and enrich the broader European landscape of mental health care. By integrating theological, ethical, and socio-political perspectives, this reflection aims to offer valuable insights for policymakers, practitioners, and stakeholders committed to promoting mental well-being and human dignity throughout Europe.

III. Mental health in the focus of EU Policy

Mental health has emerged as a critical issue within European Union (EU) policymaking, reflecting growing recognition of its profound impact on individuals, societies, and economies. Traditionally regarded as a matter primarily within the remit of national healthcare systems, mental health is now increasingly addressed through a coordinated and cross-sectoral EU approach. This shift has been driven by the rising prevalence of mental health conditions, their substantial economic costs, and heightened public and political awareness following the COVID-19 pandemic. The EU plays an important role in shaping strategic priorities, fostering cooperation among member states, and integrating mental health considerations across a broad range of policy domains.

A core pillar of EU mental health policy is the emphasis on promotion and prevention. Rather than focusing exclusively on treatment, the EU encourages Member States to a life-course address mental health, prioritising early intervention and preventive measures. By addressing risk factors such as precarious working conditions, digital overexposure, and social inequality, the EU seeks to reduce the long-term burden of mental illness and enhance societal resilience.

[3] (https://data.consilium.europa.eu/doc/document/ST-15971-2023-INIT/en/pdf)

Mental health is increasingly embedded in a wide range of EU policy domains. In employment and social policy, initiatives focus on healthy working environments, improving work–life balance, and addressing psychosocial risks at work. In education and youth policy, mental well-being is linked to learning outcomes and personal development and social inclusion. Digital policy addresses the impact of online environments on psychological health, particularly on children and young people. This integrated approach reflects a growing understanding that mental health outcomes are shaped not only by healthcare systems, also by broader social, economic, and environmental determinants.

EU mental health policy is guided by three overarching principles applicable to all EU citizens: access to adequate and effective prevention; access to high-quality and affordable mental healthcare and treatment, and the possibility of social reintegration following recovery. In October 2024, the EU Commission published a follow-up to its comprehensive approach to mental health, assessing progress to date and introducing a tracking framework to provide regular updates on the implementation of EU actions. Given the current state of mental health among EU citizens, it is evident that further efforts are required at EU level to ensure effective and sustainable support. Atruly holistic approach is needed, including persistent implementation of existing EU initiatives, such as the "Best- Practice Portal" of the EU Members States, the EU Support Package on Stigma and Discrimination and appropriate governance mechanisms, for example through the EU Health Policy Platform. Strengthening the availability, quality, and comparability of mental health data must also be a key priority.

Improving access to high-quality, person-centred mental healthcare constitutes another central objective of EU policy. The EU promotes early detection, community-based services, and continuity of care, while encouraging a gradual shift from large-scale institutionalisation. Reducing disparities between and within Member States remains a major challenge, as access to mental health services varies significantly across Europe. Through targeted funding programmes and policy coordination, the EU seeks to support more equitable, effective and sustainable mental healthcare systems. EU mental health policy places particular emphasis on vulnerable groups, including children and young people, older adults, migrants, refugees, and people with disabilities. These populations are often exposed to heightened mental health risks while simultaneously facing greater barriers to accessing appropriate care. At the same time, the EU adopts a rights-based approach that promotes mental health literacy, combats stigma, and protects individuals from discrimination. Mental health is increasingly framed as an integral component of fundamental rights, social inclusion and human dignity. The COVID-19 pandemic marked a decisive turning point in EU mental health policy, revealing widespread psychological distress and significant structural weaknesses in existing support systems. In response, mental health has gained unprecedented political visibility at the EU level, reinforcing the need for long-term, preventive, and cross-sectoral strategies. Nevertheless, considerable challenges persist, including uneven implementation across Member States, limited financial resources, and enduring stigma surrounding mental illness.

IV. Christian ethics and mental health

Catholic teaching on mental health is rooted in a broader Christian theological anthropology that affirms the inherent dignity, unity, and relational nature of the human person. Within this framework, mental illness is not understood merely as a medical or psychological concern, but as a dimension of human vulnerability that calls for compassion, solidarity, and holistic care. Christian ethics thus situates mental health within a vision of the human person that integrates biological, psychological, social, and spiritual dimensions.

At the core of Christian anthropology lies the conviction that every human being is created *imago Dei* — in the image and likeness of God — and therefore possesses intrinsic and inviolable dignity. This dignity does not depend on cognitive capacities, emotional stability, or physical health. All human beings, regardless of what ailment they suffer, are made in the image and likeness of God (Genesis 1:27) and we are called to love them "as another self"[4]. Pope John Paul II articulated this principle with particular clarity when addressing the status of persons suffering from mental illness, affirming that they always remain bearers of the divine image: "Whoever suffers from mental illness 'always' bears God's image and likeness in himself… and 'always' has the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such." This affirmation provides a fundamental ethical orientation for Catholic ethical reflection on mental health, ensuring that persons experiencing psychological distress are approached with respect and without stigma.

The Christian theological tradition further underscores that this divine image is present in the *whole* human person. Drawing from the thought of Thomas Aquinas, whose anthropology profoundly shapes Catholic thought, the image of God is not confined exclusively in the intellect or soul alone but is expressed in the entire living person — body and soul united. Aquinas argues that the human person reflects the divine image most fully as an embodied being, and that a soul separated from the body would represent this image less perfectly. This holistic understanding resists dualistic interpretations that would diminish the significance of the body or elevate purely intellectual faculties as the primary locus of human worth. Integral to this anthropological vision is the unity of body, mind, and spirit. Catholic thought understands the human person as an integrated whole whose physical, psychological, relational, and spiritual dimensions are inseparable. This perspective resonates with contemporary biopsychosocial models of mental health, while also introducing a transcendent dimension: spiritual well-being is regarded as a constitutive element of human flourishing.

From a Christian anthropological standpoint, therefore, mental health care should be multidimensional, addressing not only biological and psychological needs, but also social belonging and spiritual support. Catholic moral theology also acknowledges the relationship between mental illness and human freedom. Mental disorders can significantly affect a person's capacity for judgment, decision-making and self-determination, thereby mitigating moral culpability in certain circumstances. This insight has important implications for pastoral practice in areas such as sacramental

[4] Gaudium et Spes, 27

reconciliation, marriage tribunals, and spiritual accompaniment. By engaging with developments in psychology and psychiatry, the Church has gradually moved away from earlier tendencies to moralise or misinterpret psychological suffering, toward a more nuanced and compassionate understanding of mental illness.

A further dimension of Christian anthropology essential for understanding mental health is its relational conception of the person. The Christian understanding of personhood emerges from theological reflection on the Holy Trinity and on the unity of divine and human natures in Christ. From this perspective emerges a relational ontology, according to which persons are constituted through relationships rather than existing as isolated individuals. As the Second Vatican Council observed, there is "a certain parallel between the union existing among the divine persons and the union of the sons of God in truth and love."[5] Human flourishing, therefore, is inseparable from relationships —familial, ecclesial, and social — and mental well-being is profoundly influenced by the quality of these bonds. This relational vision has direct implications for mental health, highlighting the importance of community, solidarity, and supportive interpersonal networks.

In sum, Christian anthropology provides a rich and holistic foundation for understanding mental health. It affirms the inviolable dignity of every person, emphasizes the inseparable unity of body, mind, and spirit, acknowledges the impact of mental illness on freedom and moral responsibility, and situates human flourishing within a network of relationships. This ethical and anthropological vision not only informs Catholic teaching and pastoral practice but also contributes valuable insights to contemporary mental health discourse, highlighting that care for the mentally ill must be grounded in respect, compassion, and a holistic understanding of the human person.

V. Mental health and loneliness

Loneliness— it may be defined not merely as the absence of social contact, but as the perceived discrepancy between a person's desired and actual network of relationships, particularly where this gap entails a lack of meaningful, authentic and enduring human connection - has emerged as one of the most serious challenges to mental health in contemporary society. It constitutes a profound source of psychological, emotional, and, in many cases, spiritual suffering.[6] Increasing empirical evidence links chronic loneliness to higher risks of depression, anxiety, cognitive decline, and reduced overall well-being, underscoring its significance as a public mental health concern[7]. Within this context, the family occupies the fundamental role as the primary nucleus of human relationships and a key protective factor in addressing the challenge of loneliness. As the primary space for interpersonal belonging and care, the family is called to be a place of mutual accompaniment, trust and emotional security, particularly during periods of heightened vulnerability such as childhood and adolescence, old age, illness, or the existential crises that often

[5] Gaudium et Spes, 24

[6] Alasdair MacIntyre. After Virtue. University of Notre Dame Press. 1981.

[7] Loneliness prevalence in the EU, Joint Research Centre, European Commission, 2022

accompany major life transitions. Strong family bonds can provide emotional stability, a sense of identity, and reassurance of belonging that are essential for mental well-being.

To fulfil this role effectively, it is necessary to foster and strengthen family relationships through a culture of solidarity, empathy, and mutual understanding. Only within such an environment can the family truly function as a space in which its members receive emotional support, personal affirmation, and a sustained care. In societies increasingly shaped by individualism and the rapid pace of modern life, there is an urgent need to recover the social and moral value of family life and the practice of daily accompaniment within the household. At the same time, many families face substantial structural constraints that limit their capacity to provide care and emotional presence. Work-related pressures, economic insecurity, and time scarcity, and insufficient social support often undermine family cohesion and restrict the ability of family members to accompany one another, particularly those who are elderly, ill, or dependent. These challenges hinder their capacity to provide adequate support, making it difficult to respond effectively to the challenges of their members.

Consequently, there is a pressing need for comprehensive public policies and institutional support that promote work-life balance, encourage family cohesion, and provide financial and social assistance to families caring for young children, the elderly, or individuals with chronic illness or disabilities. Efforts to address loneliness must also extend beyond the family to encompass the wider social and community context. Catholic social teaching emphasizes that every person is inherently relational and called to live in communion with others. Active solidarity with those who experience isolation or marginalisation is therefore both a social responsibility and a moral imperative. Close accompaniment, which offers not only emotional support but also compassionate presence, is essential to counteract the deep sense of social disconnection that affects many individuals today.

In this regard, the Church plays a vital role through its parishes, ecclesial communities, and charitable and service organisations. Volunteer networks, community outreach initiatives, and pastoral accompaniment offer concrete means of reaching those in isolation and providing them with human and spiritual closeness. These community-based structures are indispensable in fostering inclusion and ensuring that no one feels forgotten, abandoned, or excluded from social and communal life.

Ultimately the promotion of a more fraternal and compassionate society—one that begins within the family and extends to the broader community—constitutes a moral duty grounded in the respect for the dignity of every person, particularly the most vulnerable. Addressing loneliness is not only a matter of individual well-being, but a collective responsibility, particularly toward the most vulnerable members of society, whose mental health and sense of belonging depend decisively on the quality of human relationships and social solidarity.

VI. Mental health and digitalisation

The digital transformation of European society is profoundly reshaping the landscape of mental health, creating new opportunities while simultaneously raising complex

ethical and anthropological questions. As highlighted in the COMECE opinion on Mental Health in Europe from 2017[8], any adequate response to these developments must be guided by an approach of "integral ecology," which considers human well-being in its full complexity by integrating environmental, economic, social, and cultural dimensions. Digitalisation, therefore, should not be assessed solely in terms of efficiency or innovation, but in relation to its impact on the dignity, relationality, and flourishing of the human person.

Within this context, digitalisation presents a clear paradox. On one hand, digital technologies offer unprecedented horizons for improving access to mental health care. Telemedicine, online therapeutic platforms, and dedicated applications represent valuable tools for addressing the shortcomings of European healthcare systems, where only about half of people with a severe mental disorder, and even fewer with mild to moderate mental disorders, receive adequate treatment.[9] On the other hand, these same technologies can lead to a reductive approach to the person, in contrast with the vision of the human person as an inseparable unity of body and soul. This tension manifests itself in various ethical dimensions that deserve careful reflection.

The first concerns the inherently relational character of care and protection of human dignity. If, as Christian anthropology affirms, people always exist in relation to other people, as a communion, digital interventions for mental health should be designed not as substitutes for human encounter, but as instruments that facilitate and support authentic interpersonal connection. While technology can broaden access to care, it cannot replace the fundamental human need for presence, empathy, and relational engagement that lies at the heart of therapeutic and spiritual accompaniment.[10] A second critical aspect concerns the relationship between digital spaces and social isolation. The latter represents a recognized predictive factor for depression and vulnerability to suicide. Digital platforms can exacerbate this isolation by fostering superficial interactions or creating the illusion of a connection that is actually absent, or they can generate authentic forms of community and support. The ethical challenge lies in orienting digital development toward the promotion of authentic relationships rather than reinforcing patterns of isolation and disengagement.

In this regard, the European Union has already begun to address these risks through regulatory frameworks such as the Digital Services Act and the Artificial Intelligence Act. The Digital Services Act contributes to the protection of mental health by requiring platforms to manage systemic risks to users' well-being, prohibiting manipulative design practices ("dark patterns"), banning targeted advertising to minors, and ensuring the availability of non-personalized recommendation systems. Complementarily, the Artificial Intelligence Act regulates AI systems to ensure that they do not impair mental health, establishing safeguards against manipulation, cognitive overload, and other forms of harm that may negatively affect users.

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[8] COMECE, Mental Health in Europe, Ethical and religious considerations, 2017

[9] www.ec.europa.eu/eurostat/statistics-explained

[10] See EU directive 2011/24 on patients rights in cross-boarder healthcare. The directive requires that care abroad needs standards of quality and safety and respects patients rights in the host country, that can include spiritual accompaniment.

Data protection and privacy constitute a further critical concern in the field of digital mental health. Digital services generate highly sensitive personal data, including information related to psychological states, diagnoses, and therapeutic processes. The protection of such data is of particular importance given the vulnerability of individuals experiencing mental health difficulties, who may be less able to fully comprehend or control how their data are collected, stored, and used. The Catholic ethical tradition, with its emphasis on preferential concern for those who are most exposed to prejudice or stigmatisation supports the need for robust safeguards and heightened standards of accountability in the handling of mental health data.

Finally, digitalisation raises complex questions regarding personal autonomy and responsibility in mental health care. As noted in the COMECE opinion, mental illness can sometimes "*deprive a person of the ability to direct their own life*"[11]. Digital tools that employ algorithms or artificial intelligence to provide therapeutic recommendations must respect what is defined as relational autonomy, recognizing that human freedom is not exercised in a vacuum but within meaningful relationships and with the support of others.

VII. Mental health and the specific challenges of women

Across the EU, women are more likely than men to experience common mental health problems such as depression, anxiety, and stress-related disorders.[12] Women are also more likely to seek help and receive diagnoses, which can further shape statistical patterns. At the same time, women's mental health challenges often remain insufficiently recognised when they intersect with poverty, migration status, disability, or caregiving roles.

EU policy increasingly acknowledges that women's mental health is shaped by structural inequalities. Women remain overrepresented in lower-paid, part-time, and precarious employment, which is associated with job insecurity and psychological stress. Payment gaps contribute to long-term financial insecurity, particularly among older women, increasing the risk of social isolation and mental distress. In addition to paid work, women continue to bear a disproportionate share of unpaid care and domestic work. Balancing paid employment with caregiving responsibilities for children, older relatives, or family members with disabilities places sustained emotional and psychological strain on women.

EU social and employment policies recognise this unequal distribution of unpaid care as a key determinant of mental well-being. Mental health and gender equality intersect in the EU's approach to work–life balance. EU initiatives promoting parental leave, carers' leave, flexible working arrangements, and access to childcare aim to reduce stress and support women's participation in the labour market. By addressing work–life conflict, these policies contribute indirectly to improving women's mental health and preventing burnout.[13] At the same time, it is also important to recognise

[11] COMECE, Mental health in Europe, Ethical and religious considerations, 2017

[12] Eurobarometer survey, October 2023

[13] EU Comprehensive Approach to Mental Health, 2023, page 12

that flexible work arrangements can have ambivalent effects, particularly when they lead to blurred boundaries between work and private life.

Experiences of domestic violence, sexual harassment, and workplace harassment are strongly associated with long-term psychological harm, including trauma, depression, and anxiety. These experiences need to be recognized as a public health issue, recognising its profound mental health consequences.[14] Migrant and refugee women, women with disabilities, older women, and single mothers face heightened mental health risks due to social exclusion, discrimination, and limited access to services.

We welcome that EU initiatives aimed at preventing violence against women, protecting victims, and supporting recovery increasingly integrate mental health considerations. A shift toward a more holistic and human- centred policy approach that recognises the interconnection between physical safety, psychological well-being, and social inclusion is essential.

VIII. Mental health and humanitarian crises

Mental health and Migration

Migration, particularly when driven by humanitarian crises, may expose individuals to situations of vulnerability that can lead to a range of psychosocial stressors significantly affecting their mental health and well-being. Migrants and asylum seekers in vulnerable situations often postpone attention to their mental health when confronted with immediate and pressing needs such as securing food, shelter, legal status, and income. This tendency is especially pronounced among those who bear responsibility for dependent family members, including children, persons with severe chronic diseases or disabilities, pregnant women, single-parents' families, and elderly people. In such contexts, psychological distress is frequently perceived as secondary to survival, even when mental well-being is severely compromised. In some cases, migrants and asylum seekers fall into the hands of traffickers that exploit them either in labour or forcing them to enter prostitution, leading to traumatic situations of truly modern slavery.

Among the factors that most profoundly destabilise migrants and asylum seekers emotionally are prolonged separation from family members, uncertainty regarding legal status and prospects, unmatched high expectations of success, and experiences of social exclusion. Feelings of loneliness, displacement, and loss of belonging are among the most common and distressing emotional experiences reported by migrants and asylum seekers. These conditions can lead to chronic stress, anxiety, and depressive symptoms, often exacerbated by exposure to trauma before, during, and after the migration journey.

Although they perceive their mental equilibrium to be on the verge of collapse, they do not seek professional assistance for their mental health; rather, they literally do not consider obtaining such attention as an available or appropriate option. This phenomenon can be attributed to several interrelated factors:

[14] See EU Directive of Violence Against Women , 2024, recital 16

1. Migrants are often compelled to prioritize basic material needs over psychological care.
2. In many countries of origin, professional mental health services are either scarce or culturally unfamiliar, limiting awareness and acceptance of such forms of support, which are seen as a stigmatizing personal failure.
3. In host countries, access to mental health care is frequently restricted by legal, linguistic, financial, and institutional barriers, as well as by the lack of adequate resources within reception and integration systems.

Some attention to the psychosocial well-being of migrants and asylum seekers is incorporated into resettlement and humanitarian assistance programmes provided by international organisations, such as the International Organisation for Migration (IOM), as well as Churches and civil society projects, which seeks to safeguard the mental and emotional health of displaced persons. These initiatives represent important steps toward recognising mental health as an integral component of humanitarian response, in the countries of origin, transit or destination. However, they remain insufficient in scale and scope. Limited resources mean that such programmes do not reach the entire migrant population, particularly those who are not accommodated in formal reception centres but instead live in precarious conditions within urban environments. They notably fail to extend to those who are not situated in localized settlements but are dispersed throughout the social fabric of cities, waiting to accumulate sufficient funds for a "cayuco" (small boat) in which they will risk their lives, without any form of assistance or support from an administration that lacks the resources to provide them. In this situation, the associated emotional instability renders individuals more vulnerable to criminal networks and even constitutes a risk of ultimately engaging in antisocial or criminal behaviors. Women are especially vulnerable in all respects, particularly when they have minors under their care.

Addressing the mental health dimensions of migration therefore requires a comprehensive and preventive approach.Awareness-raising and sensitisation campaigns on risks associated with irregular migration are necessary, as is the intensified disruption and dismantling of smuggling and trafficking networks and their complicit collaborators. However, these measures must be complemented by the development of safe and legal migration pathways that facilitate the integration of newcomers into host societies, in a manner that respects their needs and promotes the common good. In this regard, cooperation and partnerships between public authorities, civil society, Churches and faith-based organisations, and the private sector are essential. Investment in campaigns in countries of origin and transit providing accurate information about the risks associated with irregular migrations and the reality of what can be expected in the country of destination, local development initiatives, and educational and employment opportunities in countries of origin can help counteract despair and offer realistic prospects for a dignified future, particularly for young people.

Mental health and the needed support of the European Union for asylum seekers and refugees

Mental health has become an increasingly important concern within the European Union (EU) policy, particularly in relation to asylum seekers, refugees, and other

applicants for international protection. Actually, according to Regulation (EU) 2024/1356 introducing the screening of third-country nationals at the external borders, authorities involved in the performance of the tasks related to the screening should report any situation of vulnerabilities observed or reported to them, including *"persons with an immediately identifiable physical or mental disability [and] persons visibly having suffered psychological or physical trauma (...)"*[15].

TheEU Directive 2024/1346 that lays down standards for the reception of applicants for international protection establishes that *"the necessary health care should be of adequate quality and include, at least, emergency care and essential treatment of illnesses, including of serious mental disorders (…)"*[16]

Mental health is also highlighted in several further EU regulations[17] and in addition, the EU Agency for Asylum (EUAA) has published a number of documents, including the guide " Mental Health and Well-Being of Applicants for International Protection" (2024) to support the work of those who are in the first line, but also to inform policymakers on the matter.

The EU plays a significant role in shaping the policy framework that influences access to mental health support for refugees. Refugees are exposed to multifaced stress that affect mental health before, during, and after displacement, this includes often armed conflicts, persecution, inhuman or degrading treatment, torture, rape, sexual violence and the loss of family members, all of which are strongly associated with trauma-related conditions such as post-traumatic stress disorder (PTSD), depression, and anxiety. After arrival, other stress factors, including insecure legal status, restrictions on freedom of movement, social isolation, lack of or overcrowded accommodation, unemployment or irregular labour, discrimination and stigmatzation, can further exacerbate mental distress. EU policy increasingly recognizes that refugee mental health cannot be understood solely through a clinical or medical lens. It must be understood within a broader context of social, legal and structural determinants of health. Factors such as stable housing, access to education and employment, family unity, and legal certainty are all crucial for psychological well-being. Accordingly, EU policy must promote a holistic and rights-based approach that integrates mental health considerations into asylum, reception, and integration policies.

EU policy should thus encourage early identification of vulnerability and the provision of tailored, multidisciplinary assistance, recognising that delayed or inadequate intervention can have long-term consequences for mental health and social integration. Children and adolescents constitute a particularly vulnerable subgroup among the refugee population. Disrupted education, exposure to trauma, family separation, and prolonged uncertainty can significantly affect their mental and emotional development. In response, EU policy must highlight more and more the importance of child-sensitive, age-appropriate, and trauma-informed mental health services, as well as the safeguarding of children's rights throughout the asylum process, in the context of family unity and considering parental responsibility.

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[15] Para. 38 EU Regulation 2024/1356

[16] Para.46, EU Directive 2024, 1346

[17] See EU Regulation 2024/1348 and EU Regulation 2024/1347

It is important to support linguistic integration of newcomers, and when needed, to include an even stronger promotion into EU policy for the use of cultural mediators and interpreters, as well as community-based and outreach-oriented approaches to improve accessibility and trust in mental health services. The integration of mental health care into primary healthcare and social services is also encouraged to reach refugees more effectively. Finally, EU policy must fully put into practice its recognition that effective mental health support for refugees must be closely linked to broader integration and social inclusion measures. Ecological crisis and mental health

The accelerating ecological crises of our time — most notably climate change, biodiversity loss, and widespread environmental degradation — are fundamentally reshaping contemporary understandings of health and illness. These profound transformations call for a broader and more integrated perspective that moves beyond narrowly defined biomedical frameworks. One of such holistic frameworks is the One Health approach, also referred to as the concept of one, unique, and planetary health. This perspective seeks to address ecological and health crises by recognising the deep interconnections between human health, animal health, plant life and the natural environment. This strategy provides a valuable starting point for understanding and responding to the increasingly severe and pervasive effects of environmental change on mental health. Pope Francis' encyclical *Laudato Si'* echoes this interconnected vision through the repeated use of the phrase "everything is connected".

From a Christian theological perspective, health cannot be understood in isolation from the relational fabric of creation. Christian anthropology emphasizes the fact of the unique and universal interconnectedness of the human species because of its common and unique source, i.e. Creator – God. As such, ecological degradation is not merely an environmental or economic issue, but a deeply human and moral concern that affects physical, psychological, social, and spiritual well-being. Today, it is evident how this reality affects mental health. Indeed, there are visible consequences manifested through what is now referred to as eco-anxiety or climate anxiety, solastalgia, prospective distress, feelings of anger or anxiety, chronic fear, or a sense of helplessness in the face of environmental catastrophe. Those affected by such psychological issues deeply experience the unfolding ecological crises, and their condition serves as a serious call to changing our way of life. Other symptoms of this mental state are expressed through negative emotions, hopelessness, frustration, insomnia, and depression, as well as a loss of trust or faith in the future, an inability to plan, and feelings of rejection due to a lack of understanding from others.

What is particularly concerning is that this mental health issue does not only affect older generations; younger people are increasingly impacted as well. For instance, populations whose livelihoods depend heavily on farming or natural resource use are especially vulnerable to mental distress when the ecosystems they rely on are degraded. Furthermore, being forced to leave one's home due to climate-related factors or witnessing the loss of places with deep cultural or spiritual value, can undermine both the unity of communities and individuals' sense of identity—two elements that are vital for maintaining psychological well-being.

It is therefore essential to develop preventive mechanisms and appropriate measures—on the one hand, to preserve mental health, and on the other, to foster collective responsibility for our common home, and for our shared humanity. These

mechanisms and measures should be implemented through educational systems, to everyone who needs ecological education as well as awareness of the importance of mental health.

Mental Health Risks in Surrogacy - The Perspective of Women and Children

Contemporary research in neuroscience and developmental psychology reveals that the maternal-foetal bond is not merely a social or cultural construct but a deeply rooted physiological and biological process. During pregnancy, significant changes occur at multiple levels:

- Oxytocin levels increase progressively throughout pregnancy, with significant surges during childbirth[18]. This neurohormone plays a crucial role in forming the mother-child attachment, social bonding behaviours, and trust[19]. Lower oxytocin levels during pregnancy have been associated with postpartum depression symptoms.[20]
- Pregnancy induces substantial alterations in brain structure, particularly reductions in grey matter volume in areas responsible for social cognition. These changes predict postpartum maternal attachment quality and persist for at least two years after pregnancy.[21]
- Microchimerism—the exchange of cells between mother and foetus—means the surrogate mother leaves a lifelong genetic fingerprint on the child, potentially contributing to future medical risks or benefits.[22]

While empirical research on long-term psychological consequences of surrogacy remains limited due to small sample sizes and methodological limitations, several studies indicate concerning patterns regarding the psychological impacts on surrogate mothers:

- Evidence suggests that surrogate mothers experience higher rates of depression both during pregnancy and after birth compared to women carrying their own biological children ($p < 0.02$).[23]
- The separation process can cause significant emotional distress, though long-term impacts remain inadequately studied.[24]
- The disruption of natural bonding mechanisms may contribute to psychological harm.[25]

Although the long-term psychological effects of surrogacy are not yet fully understood, the disruption of natural bonding mechanisms has been identified as a potential contributor to emotional and psychological harm. From an ethical

[18] Augustine et al., 2018

[19] Eapen et al., 2014

[20] Thul et al., 2020

[21] Hoekzema et al., 2016

[22] Loike & Fischbach, 2013

[23] Lamba et al., 2018

[24] Söderström-Anttila et al., 2016

[25] Tieu, 2009; Al-Adib, 2018

perspective, these findings raise serious questions about the adequacy of existing protections for women and children involved in surrogacy arrangements.

Considering these concerns, a precautionary and ethically grounded approach is required—one that recognises the asymmetries of vulnerability inherent in surrogacy practices and prioritises the psychological well-being of all parties involved. Further interdisciplinary research, robust mental health assessment, and sustained ethical reflection are essential to ensure that policies and practices do not inadvertently normalise forms of harm that may have lasting consequences for women and children alike.

Emerging research on children born through surrogacy raises important questions regarding psychological development, attachment, and well-being. Although the overall evidence base remains limited, available longitudinal studies suggest that the specific conditions surrounding surrogacy—particularly the absence of a gestational bond with the rearing parents—may present distinct challenges for children. In addition to psychological considerations, surrogacy is associated with elevated medical risks for both women and children. Comparative studies of surrogate and non-surrogate pregnancies demonstrate higher rates of obstetric and neonatal complications in surrogacy arrangements.[26]

These findings are ethically significant insofar as they indicate that surrogacy may expose otherwise healthy women and children to avoidable medical risks. From a public health and bioethical standpoint, the acceptability of such risks warrants scrutiny, particularly when alternative paths to parenthood exist that do not involve comparable levels of medical intervention or exposure.

Furthermore, even when surrogacy is framed as altruistic, ethical concerns persist regarding the potential commodification of both women's reproductive capacities and children themselves. Contractual arrangements may implicitly reduce pregnancy and birth to services rendered, thereby instrumentalising the bodies and relationships involved.[27] In addition, so-called altruistic surrogacy may be influenced by familial pressure, emotional expectations, or moral obligation, raising questions about the extent to which consent can be considered fully free and autonomous in all cases.[28]

Nevertheless, the convergence of neuroscientific, medical, psychological, and ethical evidence points to non-negligible mental health and well-being risks associated with surrogacy. These risks justify the application of a precautionary principle in policy and ethical deliberation, particularly in light of the heightened vulnerability of women and children involved.

From an ethical perspective grounded in the protection of life and the holistic understanding of the human person, these concerns warrant serious consideration in ongoing legal, medical, and policy debates.

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[26] Woo et al., 2017

[27] Schurr & Militz, 2018

[28] Anleu, 1992

In view of all the concerns outlined above, it is necessary to heed Pope Francis's call for a universal ban on surrogate motherhood, labeling the practice "despicable" and a "grave violation of the dignity of the woman and the child".[29]

Mental Health and the Protection of Life in the Context of Palliative Care

Palliative care seeks to provide integral, compassionate and person-centred care to individuals facing terminal or chronic illnesses, ensuring that they can live with dignity until the moment of natural death. This approach prioritizes the alleviation of suffering by addressing the physical, emotional, and spiritual needs of the individual, while also providing support to the family. It emphasizes quality of life rather than merely prolonging life, fostering an environment of care and compassion during one of the most challenging phases of life. [30]

A central dimension of this holistic approach is the protection of the mental health. The prospect of imminent death often confronts individuals with profound existential distress, leading to feelings of hopelessness, anxiety, and a perceived loss of meaning—particularly when autonomy is diminished, and suffering becomes overwhelming. This reality calls for a response grounded in deep respect for life, one that offers alternatives rooted in emotional and spiritual support that enables individuals to find inner peace and hope in the face of suffering and death.

The Catholic Church affirms the inviolable dignity of every human life, especially in moments of frailty, dependency and suffering. Human worth is never contingent upon productivity, independence, or physical capacity. Within the context of palliative care, this conviction translates into a moral commitment to protect life until its natural end, rejecting both internal despair and external pressures that might lead individuals to perceive their lives as no longer valuable. Authentic care seeks not to eliminate suffering by eliminating the sufferer, but to surround the person with love, respect, and attentive accompaniment. This does not imply obliging individuals to endure unnecessary suffering but instead calls for offering the resources—both clinical and spiritual —that allow patients to discover meaning even in situations of suffering. Palliative care must therefore encompass more than physical pain relief; it should provide a human environment where patients can find emotional and spiritual consolation, deepen their understanding of life and suffering, and, when possible, reconcile with their own history and relationships. The presence of family, community, and healthcare professionals is crucial to preventing isolation and abandonment in the face of pain.

Healthcare professionals engaged in palliative care bear a particular responsibility to create a safe space where patients can freely express their fears, doubts and desires. Through attentive listening, compassionate presence, and appropriate psychological support, patients should be accompanied.

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[29] Pope Francis, 8 January 2024

[30] World Health Organization. Cancer Control: Palliative Care. WHO Guide for Effective Programmes. Geneva, Switzerland. 2007.

A truly comprehensive model of palliative care must therefore include a spiritual dimension.[31] Facing suffering naturally evokes the fundamental question of its purpose, a question that often stems from the experience of meaninglessness.[32] Modern materialistic and individualistic societies often lack the conceptual and spiritual resources to address this question adequately, but it demands a response that goes beyond suppression or escape.[33] Healthcare professionals working in palliative care, bear the responsibility of providing a space equipped with adequate tools to manage the existential suffering that arises when facing the proximity of death.

At times, patients, confronted with unbearable suffering, may feel that their life no longer has value. Palliative care should offer a response that is based on making life more bearable, dignified, and meaningful until the last moment, without making euthanasia or assisted suicide seem like the only escape to suffering. Active listening, constant presence, and psychological support are essential in providing appropriate accompaniment, enabling patients to find peace in their final moments.

The Catholic tradition offers a life-affirming response by viewing suffering through the lens of love and redemption. Though never good in itself, the experience of pain and suffering becomes an invitation to encounter God. Spiritual accompaniment is therefore desirable to help individuals explore deeper meanings of their suffering and to provide a safe space for reflection, reconciliation, and forgiveness. Through the principles of human dignity, accompaniment, and solidarity, the Church offers an ethical and pastoral response that ensures each life is safeguarded and accompanied with respect and compassion until the very end.

Incorporating spiritual care into palliative care is useful for preserving life's dignity in its most fragile form. It offers a comprehensive approach that recognizes the unique needs of everyone, ensuring that no patient is left to suffer in isolation, despair, or with a sense of meaninglessness. In the healthcare palliative setting, it is essential for professionals to be prepared not only to address patients' medical needs but also to recognize and respond to their spiritual and existential questions.[34] [35] However, current research indicates that spiritual care remains insufficiently integrated into many healthcare systems, due to factors such as time constraints, cultural or institutional barriers, and gaps in professional education.[36] Addressing these limitations is a necessary step toward improving the quality of end-of-life care. By doing so, society and institutions can better accompany the suffering person with dignity and compassion, affirming life even in its final, most fragile moments.

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[31] See EU Directive 2011/ 24 on patients rights in cross-boarder healthcare. This directive requires that care abroad needs standards of quality and safety and respects patients rights in the host countries. Due to the EU Charter on Fundamental Rights and the enshrined freedom of religions this can include requests for spiritually appropriate care

[32] Pope John Paul II. 1984. Salvifici Doloris: On the Christian meaning of human suffering. Vatican Press. n 9

[33] Lewis, C. S. The Problem of Pain. HarperOne, 2001.

[34] Delgado-Guay MO. Spirituality and religiosity in supportive and palliative care. Curr Opin Support Palliat Care. 2014 Sep;8(3):308-13.

[35] El Nawawi NM, Balboni MJ, Balboni TA. Palliative care and spiritual care: the crucial role of spiritual care in the care of patients with advanced illness. Curr Opin Support Palliat Care. 2012 Jun;6(2):269-74. doi:

[36] Evangelista CB, Lopes ME, Costa SF, Batista PS, Batista JB, Oliveira AM. Palliative care and spirituality: an integrative literature review. Rev Bras Enferm. 2016 Jun;69(3):591-601.

IX. Conclusion

This reflection presents mental health as a profound moral and social responsibility, rooted in the key principles of Catholic Social Teaching: human dignity, the common good and solidarity. At its core, it affirms that every person—especially the ones experiencing loneliness, vulnerability, or displacement—possesses inherent dignity. Addressing loneliness as a public health priority and strengthening families highlights the role of primary communities of care, where human relationships and mutual support are first nurtured. Community-based and faith-informed networks further embody solidarity, ensuring that no one is left in isolation. In the digital sphere, the paper stresses that technology must serve the human person, not replace authentic relationships. This reflects the Catholic Social Teaching insistence that all innovation needs be guided by respect for human dignity and the ethical pursuit of the common good, with special protection for the most vulnerable. Special attention to women, particularly caregivers, underscores the need for justice and recognition of their social contribution, promoting policies that support their well-being in a holistic and human-centered way. In the context of migration, the text reflects a deeply integral vision of the human person, recognizing that mental health is shaped by social, legal, and economic conditions. The call to support refugees through inclusion, stability, and cultural mediation embodies the Catholic Social Teaching commitment to solidarity and the preferential option for the poor and vulnerable. The protection of life emerges as a unifying principle. From ecological concerns to bioethical questions and palliative care, the reflection emphasizes an integral ecology perspective and a consistent ethic of life. It affirms the dignity of the human person from conception to natural death, advocating for ethical vigilance in areas such as surrogacy and for compassionate, spiritually attentive care at the end of life. Overall, the text calls for policies that place the human person at the center, foster authentic relationships and community, and promote a society where care, dignity, and solidarity guide all responses to mental health challenges.