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Pastoral care and unmet need in acute mental health services

Ministers of religion are often approached as a last resort when all else fails. When family and friends are in despair, when services are unresponsive, and when risk is escalating, it is frequently the priest, imam, or rabbi who is called. We are two rabbis experienced in care in faith communities, and we have learned what acute mental illness means for us: sitting with congregants, friends, and families at the darkest times of their lives, offering spiritual guidance and practical help.

30 years ago, one of us supported a man who arrived with a large box of papers, saying: “Please store my evidence: there are people out to get me, and you need to keep this safe.” He had left his wife and children and was sleeping in his car, neglecting himself and at risk. It took coordinated work with excellent UK National Health Service (NHS) services to find him and take him to safety. We cannot rely on that standard today. We have first-hand experience of late-night calls from suicidal congregants when the ambulance does not come, when hospitals cannot access records, when there are no named general practitioners, and when the crisis team does not respond.

This pastoral dilemma has clinical consequences. Pastors skilled in spiritual accompaniment cannot provide a place of safety, a medication review, or sustained risk management. In acute psychosis or suicidal crisis, our help is not enough. We stand at the door, unable to enter the room: able to listen, able to offer spiritual guidance, and sometimes to spread a little calm, but unable to substitute for statutory crisis care. Our deepest fear is that when the NHS fails our congregants, we will be the ones conducting the funeral. It is painful to read accounts of the Nottingham Inquiry: why do the same errors keep recurring?[1]

Policies promise timely support and “no wrong door”,[2,3] but in practice we both find ourselves holding risk without authority, clinical training, or legal powers, and without a dependable route to urgent clinical assessment.

Because we are not clinicians, our credential is proximity: faith leaders will always be there when people cannot access care, or when care is fragmented or unaccountable. Good practice can be found in structured, consent-based liaison between volunteer referrers and crisis teams.[4] Such schemes need to be rolled out more widely, so that risk can be handed promptly to clinicians, families are not left without a route into care, and pastors can relax knowing that competent help is on its way.

We ask the clinical community: how can the NHS be rebuilt around responsibility, continuity, and safety—not merely targets—so that those outside the system are not left to hold emergencies they cannot resolve?

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Ultra-processed food policy must regulate the screen as well as the street

Gyorgy Scrinis and colleagues make a strong case for moving ultra-processed food (UPF) policy beyond narrow reformulation agendas towards broader fiscal, labelling, marketing, and retail measures.[1] Yet one policy domain remains underdeveloped in this discussion: the digital food environment.

Much food-environment research and policy still assumes that exposure is determined mainly by neighbourhood retail structure (ie, outlet density, store proximity, or what is sold within a buffer around homes and schools); this assumption is now incomplete. Digitalisation is reshaping all major dimensions of the food environment, including availability, accessibility, price, marketing, convenience, and desirability.[2] Evidence from the digital food retail environment suggests that online food delivery platforms disproportionately promote unhealthy options, intensify discounting and visual marketing, and make healthy comparisons more difficult.[3] Meal delivery applications also create hybrid food environments, in which households can access a much wider set of outlets than their local streetscape would suggest.[4]

This expansion of the digital food environment matters for policy. If governments regulate only physical retail while leaving recommender systems, sponsored placement, push notifications, application-based

discounts, and delivery-only brands largely untouched, they risk regulating the street while leaving the digital screen unregulated. WHO has already called for stronger protections against harmful food marketing to children, including in digital settings.[5] That logic should now be extended more explicitly to population-level UPF policy.

I therefore suggest one addition to the policy agenda proposed by Scrinis and colleagues: treat digital food environments as a policy domain in their own right. This means incorporating delivery platforms and ghost kitchens into food-environment surveillance; requiring transparency and independent auditing of platform ranking, promotion, and pricing practices; restricting paid placement and targeted marketing of UPFs, especially where children and adolescents are exposed; and treating app-based access as part of food availability, not a side issue.

In increasingly hybrid food systems, neighbourhood measures alone capture only partial exposure. Policies focused only on zoning, physical outlet mix, or school buffers will increasingly mismeasure the pathways through which UPFs reach households. Public health policy must regulate not only where food is sold, but also how it is algorithmically surfaced, discounted, and delivered.

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See **Online** for appendix

For more on the **estimated need for rehabilitation** see https://vizhub.healthdata.org/rehabilitation

WHO global rehabilitation indicators meet rising health needs

At its 158th Executive Board, the Director-General of WHO presented a report outlining global indicators to monitor the integration of rehabilitation into health systems.[1] The indicators were selected following a member states consultation between November, 2024, and March, 2025. This milestone follows the 2023 World Health Assembly (WHA) 76.6 Resolution for strengthening rehabilitation in health systems, which calls for developing rehabilitation services at all levels of the health system to address huge unmet population needs.[2]

Demographic shifts, a rising prevalence of non-communicable diseases, and a new era of conflict pressure modern health systems with increasing demands for rehabilitation. The Global Burden of Diseases, Injuries, and Risk Factors Study 2021 estimated that 2·6 billion people could benefit from rehabilitation.[3] Historically, health systems were built to treat disease and prevent death. Rehabilitation emerged later, often in response to those affected by war and infectious disease with permanent disability. Today, rehabilitation is recognised as a core health strategy to achieve optimal functioning, improve the outcome of other health interventions, and enhance wellbeing as well as reducing societal costs in chronic conditions.[4] Unfortunately, current health system monitoring remains focused on morbidity and mortality and fails to capture these effects adequately.

The WHO global rehabilitation indicator set aims to fill this gap by enabling assessment of a country's capacity to meet population rehabilitation needs. The framework allows tracking of countries' governance (including preparedness for health emergencies), financing, workforce, health information systems, and service delivery. Within this set, a service use indicator measures access to rehabilitation services that can be disaggregated by major condition groups requiring rehabilitation (ie, musculoskeletal, neurological, mental health, respiratory, cardiovascular conditions, sensory impairments, and cancer). This disaggregation helps member states identify priorities and contextually relevant conditions, and begin systematically tracking rehabilitation service coverage across clinical populations.

In response to the WHA Resolution's request, an additional effective coverage indicator was developed, methodologically requiring the selection of a tracer health condition, to serve as a tracer indicator for health system performance assessment.[5] The WHO global rehabilitation indicators are intended to shift the focus of global health assessment from mortality and morbidity to include functioning as a third fundamental health outcome.[6] The appendix shows an overview of the indicators.

The WHA Resolution requests the WHO Director-General to publish the first global status report on rehabilitation and the global indicators could serve as a baseline. These metrics must be integrated into national health information systems with the support of WHO, non-state actors, development partners, and academic institutions. By adopting and funding data collection for these indicators, countries can make rehabilitation visible, ensuring that every person affected by disease or injury, every ageing person, and everyone experiencing disability has a measurable path to a life of independence and participation.