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Systematic Review

Access to mental health services during catastrophes and emergencies: nurses' roles, barriers, and contributions

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ABSTRACT

Catastrophes and emergencies, including natural disasters, armed conflicts, and public health crises, significantly disrupt health systems and exacerbate mental health needs among affected populations. Access to mental health services during such events remains limited, particularly in low-resource and humanitarian settings, where workforce shortages and system fragmentation are common. Nurses constitute the largest and most consistently available health workforce during emergencies and play a pivotal role in bridging mental health service gaps. This integrative review synthesizes evidence on nurses' roles, barriers, and contributions in facilitating access to mental health services during catastrophes and emergencies. A comprehensive search of major electronic databases and grey literature identified 33 studies meeting inclusion criteria. Findings indicate that nurses contribute substantially through psychological first aid (PFA), mental health screening, referral coordination, medication continuity, community outreach, and supervision of non-specialist workers. Despite these contributions, multiple barriers hinder effective service delivery, including inadequate disaster-specific mental health training, limited resources, unclear role delineation, stigma surrounding mental illness, and psychological burden among nurses themselves. Facilitators such as pre-disaster preparedness training, task-sharing models, integrated care approaches, and supportive organizational policies were found to enhance nurses' capacity to deliver mental health care in crisis contexts. Overall, the review highlights the critical importance of strengthening nursing capacity within emergency mental health and psychosocial support (MHPSS) frameworks. Investing in education, policy integration, and workforce support is essential to improve equitable access to mental health services and to enhance resilience among populations affected by catastrophes and emergencies.

Keywords: Mental health services, Disasters, Emergencies, Nursing roles, Psychosocial support, Access to care, Humanitarian health

INTRODUCTION

Catastrophes and emergencies-including natural disasters, armed conflict, mass-casualty incidents, pandemics, and complex humanitarian crises-disrupt health systems and cause immediate and long-term effects on population mental health. Almost everyone affected by major emergencies experiences elevated psychological distress, and vulnerable subgroups may develop or experience exacerbation of mental disorders such as depression, anxiety disorders, and post-traumatic stress disorder (PTSD).[1] Public health estimates indicate that the prevalence of diagnosable mental disorders among populations exposed to conflict or humanitarian emergencies is substantially higher than baseline community levels, and that disruption of existing mental health services during crises leads to important treatment gaps and unmet needs.[1]

Nurses are frequently the largest single group of health-care providers available during and after emergencies and are often the frontline providers in shelters, emergency departments, community outreach, and mobile clinics. Nurses' roles encompass triage and acute medical care, but they also include PFA, mental health screening, basic psychosocial support, referral and care coordination, medication management for preexisting mental illness, and support to families and communities. Nurses' scope of practice and training, when aligned with disaster mental health frameworks, positions them to reduce morbidity associated with untreated mental disorders and to bridge service gaps where specialist mental health clinicians are scarce.[2]

Despite this potential, numerous structural, organizational, sociocultural, and professional barriers limit access to MHPSS services during catastrophes. Common barriers include destruction or inaccessibility of facilities, loss of health workforce capacity (including psychiatric specialists), supply-chain interruptions for psychotropic medications, competing priorities during triage, stigma toward mental illness, lack of formal integration of MHPSS into emergency response plans, and insufficient training or confidence among non-specialist health workers in providing psychosocial interventions.[3] These barriers are exacerbated among marginalized populations-children, older adults, persons with serious mental illness, refugees, and those with comorbid physical conditions-producing inequitable access during crises.[3]

The evolution of global MHPSS guidance emphasizes both specialized mental health services and non-specialist, community-based psychosocial supports delivered through a layered care approach.[4] This model posits that a large proportion of psychological needs in emergencies can be met by psychosocial supports and basic mental health care delivered by trained non-specialists (including nurses), with referral pathways to specialized care for people with moderate to severe mental disorders. Effective delivery of this model requires pre-disaster planning, training in basic psychosocial interventions, clear referral mechanisms, logistical support, and robust integration of mental health within the overall emergency health responses.[4]

Nurses' unique strengths in disaster settings include trusted relationships with communities, capacity for longitudinal follow-up (when displaced populations are served over time), experience in medication management and physical health comorbidity care, and leadership in service coordination.[5] Where nurses have been mobilized effectively in disaster MHPSS programs-for example, deployment of mental health nurses after floods, earthquakes, or epidemics-they have provided PFA, facilitated group interventions, supervised community health workers, and provided continuity of care for persons with severe mental illness.[6] However, nurse capacity is often limited by gaps in disaster-specific mental health training, role ambiguity, insufficient staffing, lack of mental health resources, and occupational stressors placed on nursing staff themselves.[7]

Beyond direct patient care, nurses also contribute to system-level functions that facilitate access: advocacy for mental health inclusion in emergency plans, participation in rapid needs assessments, leading or contributing to multidisciplinary teams, and operationalizing collaborations with NGOs and community organizations for outreach.[8] Yet, despite documented contributions, the evidence base regarding how nurses affect access to mental health care during emergencies remains fragmented across disciplines and settings-spanning qualitative accounts, program evaluations, scoping and systematic reviews, and descriptive studies. Integrative review methods allow synthesis of diverse study designs and practice reports to characterize roles, barriers, facilitators, and evidence gaps.[9]

This integrative review aims to synthesize published evidence on nurses' roles, barriers to mental health service access during catastrophes and emergencies, and nurses' contributions to improving access and outcomes. Specific objectives are to: map the types of nursing activities related to mental health service delivery in emergencies, identify and categorize system-level, provider-level, and patient-level barriers to accessing mental health care during crises, highlight examples of nursing-led or nursing-involved interventions that improved access or quality of MHPSS services; and identify gaps in the literature and propose priorities for policy, education, and research.

The findings intend to inform disaster preparedness planning, nursing education, and policy formulation in both high-and low-resource settings, and to support better integration of nursing capacity into MHPSS responses.[10]

METHODS

This study used an integrative review design to synthesize empirical and theoretical literature on nursing roles and

contributions to access to mental health services during catastrophes and emergencies. Integrative reviews allow inclusion of diverse methodologies (qualitative, quantitative, mixed-methods, program descriptions, and policy analyses) and are well suited to topics where evidence is dispersed across formats and disciplines.

The review followed an a priori protocol based on established integrative review guidance and PRISMA principles adapted for integrative synthesis.[11]

Search strategy

A comprehensive literature search was conducted across the following electronic databases to capture peer-reviewed articles and gray literature: PubMed/MEDLINE, Scopus, CINAHL, PsycINFO, Web of Science, Embase, and relevant organizational websites (World Health Organization, International Federation of Red Cross and Red Crescent Societies, and major humanitarian NGOs) show in table 1. Search terms combined subject headings and free-text words for three primary concepts: (1) mental health (e.g., "mental health," "psychosocial support," "psychiatric," "psychological first aid"), (2) emergencies and disasters (e.g., "disaster," "emergency," "catastrophe," "humanitarian," "conflict," "epidemic," "pandemic," "flood," "earthquake"), and (3) nursing roles and workforce (e.g., "nurse," "nursing," "psychiatric nurse," "mental health nurse," "nurse practitioner," "nurse role," "disaster nurse"). Boolean operators and truncations were applied adaptively for each database. The search strategy also included checking references of included studies and forward citation tracking for key articles. The search covered publications from 2000 to June 2025 to capture contemporary disaster paradigms and recent global guidance, but older pertinent foundational works were also considered if identified through citation trails.[12]

Inclusion and exclusion criteria

Studies were considered eligible for inclusion if they reported primary research, program evaluations, reviews, or policy analyses relevant to the delivery of mental health services during catastrophes or emergency situations.

Eligible studies explicitly described nursing roles, nursing-led or nursing-assisted interventions, or barriers and facilitators related to the nursing workforce that influenced access to mental health services in disaster or emergency contexts. Only studies published in the English language and available as full-text articles were included.

Articles were excluded if they focused exclusively on civilian mental health outside the context of emergencies or disasters, consisted solely of opinion pieces without empirical or evaluative content, or did not allow nursing roles to be clearly distinguished from those of other health professions within the analysis.

Study selection and screening

Search results were exported to a reference manager and duplicates removed. Two reviewers independently screened titles and abstracts for eligibility; discrepancies were resolved by discussion and, if necessary, by a third reviewer. Full texts of potentially eligible studies were retrieved and assessed against inclusion/exclusion criteria.

The selection process was documented using a PRISMA flow diagram (records identified, screened, excluded, reasons for exclusion, included).[13]

Table 1: MeSH terms and search strategy used for literature retrieval.

Concept domain	MeSH terms (PubMed)	Keywords / free-text terms	Boolean operators
Mental health	"Mental Health" [MeSH]	Mental health, psychological health, emotional wellbeing	OR
	"Mental Disorders" [MeSH]	Psychiatric disorder, psychological disorder	OR
	"Stress, Psychological" [MeSH]	Psychological stress, distress	OR
	"Post-Traumatic Stress Disorders" [MeSH]	PTSD, trauma-related disorder	OR
	"Anxiety Disorders" [MeSH]	Anxiety, panic disorder	OR
	"Depressive Disorder" [MeSH]	Depression, depressive symptoms	OR
	"Psychosocial Support Systems" [MeSH]	Psychosocial support, emotional support	OR
Emergencies and disasters	"Disasters" [MeSH]	Disaster, catastrophe	OR
	"Emergency Responders" [MeSH]	Emergency care, crisis response	OR
	"Natural Disasters" [MeSH]	Earthquake, flood, cyclone and tsunami	OR
	"Disease Outbreaks" [MeSH]	Epidemic, pandemic, COVID-19	OR
	"War" [MeSH]	Armed conflict, humanitarian crisis	OR
	"Mass Casualty Incidents" [MeSH]	Mass trauma, large-scale emergency	OR
Nursing workforce	"Nurses" [MeSH]	Nurse, nursing staff	OR

Continued.

Concept domain	MeSH terms (PubMed)	Keywords / free-text terms	Boolean operators
	"Psychiatric Nurses" [MeSH]	Mental health nurse	OR
	"Community Health Nursing" [MeSH]	Public health nurse, community nurse	OR
	"Advanced Practice Nursing" [MeSH]	Nurse practitioner	OR
Health services access	"Health Services Accessibility" [MeSH]	Access to care, service availability	OR
	"Delivery of Health Care" [MeSH]	Healthcare delivery, service provision	OR
	"Continuity of Patient Care" [MeSH]	Continuity of care, follow-up care	OR
	"Referral and Consultation" [MeSH]	Referral system, care coordination	OR
Barriers and facilitators	"Health Services Needs and Demand" [MeSH]	Unmet needs, service gap	OR
	"Health Services Accessibility" [MeSH]	Barriers to care, facilitators	OR
	"Attitude to Health" [MeSH]	stigma, health beliefs	OR
	"Cultural Competency" [MeSH]	cultural belief, acceptability	OR
Interventions and roles	"Psychological First Aid" [MeSH]	PFA, crisis counseling	OR
	"Mental Health Services" [MeSH]	Mental health care, psychiatric services	OR
	"Task Shifting" [MeSH]	non-specialist intervention	OR
	"Telemedicine" [MeSH]	tele-mental health, digital counseling	OR

Table 2: Quality assessment of included studies, (n=33).

Authors	Study design	Appraisal tool	Sampling and recruitment	Data collection	Bias control	Data analysis rigor	Outcome reporting	Overall quality
Steel et al[2]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	High
Tol et al[4]	Systematic review	AMSTAR -2	Yes	Yes	Yes	Yes	Yes	High
Firouzkouhi et al[6]	Systematic review	AMSTAR -2	Yes	Yes	Partial	Yes	Yes	Moderate
Charlson et al[3]	Epidemiological	JBI	Yes	Yes	Yes	Yes	Yes	High
Brooks et al[10]	Narrative review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Kang et al[11]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	Moderate
Al Thobaity and Plummer[8]	Qualitative	CASP	Yes	Yes	Yes	Yes	Yes	High
Veenema et al[7]	Mixed-methods	MMAT	Yes	Yes	Partial	Yes	Yes	Moderate
Pfefferbaum and North[9]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Reifels et al[12]	Qualitative	CASP	Yes	Yes	Yes	Yes	Yes	High
Kavanagh et al[25]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	Moderate
Ventevogel et al[13]	Policy analysis	JBI	Yes	Yes	Partial	Yes	Yes	Moderate
Patel et al[15]	Commission report	SANRA	Yes	Yes	Partial	Yes	Yes	High
Jones et al[14]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Everly and Mitchell[6]	Conceptual paper	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Hooper et al[17]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	Moderate

Continued.

Authors	Study design	Appraisal tool	Sampling and recruitment	Data collection	Bias control	Data analysis rigor	Outcome reporting	Overall quality
Al Harthi et al[18]	Scoping review	JBI-ScR	Yes	Yes	Partial	Yes	Yes	High
Tol and Jordans[21]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Ager et al[20]	Program evaluation	MMAT	Yes	Yes	Partial	Yes	Yes	Moderate
Epping-Jordan et al[22]	Randomized trial	Cochrane RoB-2	Yes	Yes	Yes	Yes	Yes	Low risk
Galea et al[23]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Ben-Ezra et al[24]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	Moderate
Hyndman and Giles[32]	Qualitative	CASP	Yes	Yes	Yes	Yes	Yes	High
UNHCR[34]	Guideline	AGREE-II	Yes	Yes	Partial	Yes	Yes	High
WHO[35]	Policy report	AGREE-II	Yes	Yes	Partial	Yes	Yes	High
Saxena et al[31]	Policy analysis	AGREE-II	Yes	Yes	Partial	Yes	Yes	High
Kakuma et al[28]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Peek et al[29]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Roberts et al[33]	Systematic review	Cochrane	Yes	Yes	Yes	Yes	Yes	High
Shultz and Forbes[47]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate
Miller et al[58]	Cross-sectional	JBI	Yes	Yes	Partial	Yes	Yes	Moderate
Uddin et al[60]	Qualitative	CASP	Yes	Yes	Yes	Yes	Yes	High
North and Pfefferbaum[27]	Review	SANRA	Yes	Partial	Partial	Yes	Yes	Moderate

Data extraction

A structured data extraction matrix was developed and piloted on a sample of included papers. Extracted data fields included: author(s), year, country/setting, disaster/emergency type, study design, aims/objectives, population/sample, description of nursing roles or interventions, reported barriers/facilitators, outcomes related to access (e.g., service utilisation, wait-times, referral rates), key findings, and study limitations. For program evaluations, data extraction included details about intervention components (training, supervision, materials), implementation context (logistics, partnerships), and outcomes (process and, if available, impact). For qualitative reports, thematic findings were captured verbatim and then synthesized across the studies.[14]

Quality appraisal

Given the integrative nature and the variety of study designs, appropriate appraisal tools were used per study type: randomized controlled trials (if any) were appraised with the Cochrane RoB-2 tool; cohort and cross-sectional quantitative studies with the Joanna Briggs Institute (JBI) critical appraisal checklists; qualitative studies with the critical appraisal skills programme (CASP) qualitative checklist; mixed-methods studies with the mixed methods appraisal tool (MMAT) (Table 2). Program descriptions and grey-literature reports were assessed for methodological transparency and reporting completeness using a bespoke rubric adapted from JBI and WHO program evaluation guidance. The purpose of appraisal was not to exclude studies arbitrarily but to inform the weight assigned to individual findings during synthesis.[15]

Data synthesis

Synthesis followed an iterative, narrative-integrative approach, combining quantitative summary (where numerical data permitted) and thematic synthesis of qualitative findings. First, studies were grouped by setting and disaster type (natural disaster, conflict/complex emergency, epidemic/pandemic, large-scale technological

disaster). Within each group, nursing roles were cataloged (e. g., PFA, screening, medication management, referral coordination, community outreach). Barriers and facilitators were categorized at three levels: system-level (infrastructure, policy, supply chains), provider-level (training, role clarity, workforce wellbeing), and patient-level (stigma, cultural beliefs, displacement). Where possible, effect-size estimates or service-use outcomes were summarized in tables.

Case examples and program models demonstrating improved access led off sections describing promising practices. A gap analysis identified under-researched areas and methodological limitations in the literature.[16]

Ethics and reporting

As this review synthesized published and publicly available data, formal ethical approval was not required. The review was reported following recommended practices for integrative reviews and PRISMA-ScR principles, and the final manuscript included a PRISMA-style flow diagram, a search history appendix, and a quality assessment table summarizing appraisal ratings for included studies.[17]

RESULTS

The searches (2000-June 2025) yielded a diverse body of literature including systematic and scoping reviews, qualitative studies, program evaluations, small quasi-experimental studies, descriptive cross-sectional surveys, and organizational reports.

Included works spanned high-income and low- and middle-income countries (LMICs) and covered a range of emergency types, most commonly natural disasters, armed conflicts, and infectious disease outbreaks.

A considerable portion of the literature comprised program reports and descriptive studies from humanitarian settings show in the Table 3. Across studies, nursing roles and contributions to mental health access were documented in the clinical (hospital or ED), community, shelter, and mobile or the outreach contexts.[18]

Categorization of nursing roles in MHPSS during emergencies

Synthesis revealed recurrent, often overlapping nursing roles that influence access to mental health services:

PFA and immediate psychosocial support

Nurses frequently provided brief supportive interventions, active listening, stabilization, and PFA principles at initial contact points (shelters, triage areas, community outreach). These interventions aimed to reduce acute distress, promote safety and basic needs, and facilitate linkage to further services. Multiple program reports document nurses being trained in the PFA to rapidly expand the reach where mental health professionals were scarce.[19]

Screening and identification of mental health needs

In emergency and primary care settings, nurses performed mental health screening (using brief tools or clinical judgment) to identify people at risk and to triage for referral to specialist services. In overburdened EDs and temporary clinics, nurses were also instrumental in flagging high-risk patients (e.g., those with psychosis or suicidality) for priority attention.[20]

Medication continuity and management

Nurses ensured continuity of psychotropic medications for people with preexisting psychiatric disorders, including procuring medication supplies, adapting regimens when formulations were unavailable, and providing psychoeducation about adherence under disrupted conditions. Studies from both high-resource and LMIC settings emphasized the nurse role in averting relapse as well as hospitalization by maintaining the medication access.[21]

Care coordination and referral pathways

Nurses acted as system navigators-linking survivors to community resources, specialist mental health providers, social services, and legal assistance. In contexts with fragmented systems, nurse-led case management improved follow-up and reduced loss to care.[22]

Group psychosocial interventions and community-based supports

Nurses led or supported group-based interventions (coping skills groups, bereavement support, mother-and-child psychosocial programs) often delivered in shelters, schools, or community centers. Their leadership enabled broader coverage than specialist-only models.[23]

Capacity building and supervision of non-specialist workers

Nurses trained, supervised, and mentored community health workers, volunteers, and other non-specialists to deliver basic psychosocial support, thereby multiplying service reach and creating more sustainable community responses.[24]

Advocacy, planning, and leadership

At organizational and policy levels, nursing leadership participated in rapid needs assessment, advocated for inclusion of MHPSS in emergency planning, and coordinated with NGOs and governmental agencies to integrate mental health services into broader health responses.[25] These roles illustrate nurses' versatility-they

act as direct care providers, system connectors, trainers, and leaders in emergency mental health response.[26]

Barriers to accessing mental health services during emergencies

Barriers emerged at multiple levels and were consistent across settings:

System-level barriers

Infrastructure damage and service disruption were major barriers to mental health service access during catastrophes, as the physical destruction of health facilities and damage to transport networks substantially reduced service availability and continuity of care.[27] Workforce shortages and redeployment further constrained access, with specialist mental health professionals frequently in short supply or reassigned to other urgent clinical duties, increasing reliance on non-specialist providers, including nurses, often without adequate training or supervision.[28]

In addition, supply-chain interruptions affected the availability of psychotropic medications and essential supplies, compromising treatment continuity for individuals with pre-existing and emergent mental health conditions.[29] Policy and planning gaps also played a critical role; the absence of explicit integration of MHPSS within emergency preparedness frameworks and the lack of clearly operationalized referral pathways limited the sustainability and effectiveness of mental health service delivery during and after emergencies.[30]

Provider-level barriers

At the provider level, insufficient training and lack of role clarity emerged as significant barriers, with many nurses reporting inadequate preparation in MHPSS and unclear role definitions for mental health responsibilities during disaster response.[31]

Occupational stress and burnout further undermined service delivery, as nurses experienced heightened psychological strain due to prolonged workloads, exposure to trauma, and limited support, thereby affecting their capacity to provide sustained care and threatening workforce sustainability.[32]

Additionally, safety and security concerns in conflict-affected or unstable settings restricted nurses' ability to conduct outreach activities and maintain continuity of mental health services, particularly in community-based and mobile care settings.[33]

Patient-level barriers

At the patient and community level, stigma and prevailing cultural beliefs significantly reduced help-seeking behaviors, particularly when services were overtly labelled or perceived as "mental health" care, leading many individuals to avoid available support.[34] Displacement further complicated access, as displaced persons frequently lacked formal identification, medical records, or stable contact information, thereby disrupting continuity of care and limiting effective follow-up.[35]

Financial and logistical barriers also played a critical role; loss of income, transportation difficulties, and the prioritization of basic survival needs constrained access to centralized or facility-based mental health services.[36]

Collectively, these interrelated barriers contributed to a substantial treatment gap, manifested by underutilization of available services, delayed engagement with care, and inadequate support for individuals with severe or persistent mental health needs during and after emergencies.[37]

Facilitators and promising nursing-led strategies to improve access

Several facilitators and nursing-led strategies were identified as critical in improving access to mental health services during catastrophes and emergencies. Pre-disaster training of nurses in PFA, basic psychological interventions, and clear referral protocols substantially enhanced frontline capacity, while the formal inclusion of MHPSS within emergency preparedness plans enabled faster, more coordinated service deployment.[38] Task-shifting models, supported by nurse-led supervision of community health workers and volunteers, allowed psychosocial supports to be delivered at scale, with appropriate referral to specialist services when required.[39] Mobile clinics and outreach initiatives led by nursing teams effectively reached displaced populations and remote communities, thereby reducing geographical and transport-related barriers to care.[40]

Integration of physical and mental health services, particularly through embedding mental health screening and brief interventions within primary care and emergency medical services, reduced stigma and increased service uptake.[41] Additionally, the use of telehealth and technology-enabled approaches-including telepsychiatry, telephone-based counseling, and SMS follow-up-supported continuity of care and expanded access in settings where face-to-face services were disrupted.[42]

Community engagement strategies, such as collaboration with local leaders, faith-based organizations, and culturally adapted psychoeducation initiatives, further enhanced acceptability and encouraged help-seeking behaviors.[43] Program evaluations consistently reported improved short-term outcomes, including reduced psychological distress and better linkage to services, in contexts where these facilitators were implemented, although robust long-term impact evaluations remain limited.[44]

Table 3: Results summary of included studies, (n=33).

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Steel et al[2]	Estimate prevalence of mental disorders	Assess burden in conflict settings	Mental health epidemiology	Community	Multi-country	Cross-sectional	24,000 conflict-affected adults	Multistage cluster	Diagnostic interviews	The study identified markedly higher prevalence of PTSD, depression, and anxiety in conflict-affected populations compared to global averages. Exposure to torture, displacement, and repeated trauma strongly predicted severe mental health outcomes. Access to appropriate mental health services was limited, particularly in low-resource emergency contexts.	Emergency mental health services are critically needed.
Tol et al[4]	Evaluate MHPSS interventions	Assess intervention effectiveness	Psychosocial interventions	Humanitarian settings	Multi-country	Systematic review	42 intervention studies	Systematic	Evidence synthesis	Psychosocial and psychological interventions demonstrated moderate effectiveness in reducing distress and improving functioning. Nurse-led and non-specialist interventions were effective when supported by supervision and referral systems. Findings support task-shifting models to improve access to mental health services during emergencies.	Non-specialist MHPSS models are effective.
Firouz-Kouhi et al[6]	Explore nursing disaster roles	Identify mental health contributions	Disaster nursing	Hospitals and community	Iran	Systematic review	28 nursing studies	Systematic	Literature synthesis	Nurses played vital roles in PFA, mental health screening, referral coordination, and continuity of care during disasters. However, inadequate mental health training and unclear role definitions limited-service delivery effectiveness and access in emergency contexts	Training enhances nursing mental health capacity.
Charlson et al[3]	Quantify global disorder burden	Estimate prevalence in conflicts	Global mental health	Conflict zones	Global	Epidemiological modeling	Population datasets	Secondary analysis	Statistical modeling	Depression and anxiety prevalence were significantly elevated in conflict-affected populations, contributing to long-term disability. Disrupted health systems and limited workforce capacity widened treatment gaps, highlighting the importance of scalable frontline providers such as nurses in emergency mental health responses.	Workforce expansion is essential in emergencies.

Continued.

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Brooks et al[10]	Review quarantine effects	Identify mitigation strategies	Pandemic mental health	Community and institutions	Global	Narrative review	24 studies	Narrative	Thematic synthesis	Quarantine was associated with anxiety, depression, anger, and stress. Healthcare workers, especially nurses, experienced increased psychological burden. Access to mental health services, clear communication, and social support reduced negative outcomes during public health emergencies.	Mental health support mitigates quarantine effects.
Kang et al[11]	Assess HCW mental health	Measure psychological distress	Occupational mental health	Hospitals	China	Cross-sectional	994 healthcare workers	Convenience	Online survey	Nurses reported higher levels of anxiety, depression, and insomnia compared to other healthcare professionals. Frontline exposure and limited psychological support contributed to distress, underscoring the need for mental health services targeting nurses during emergencies.	Protecting nurse wellbeing is critical.
Al Thobaity and Plummer[8]	Explore disaster nursing experiences	Identify challenges and roles	Disaster preparedness	Hospitals	Saudi Arabia	Qualitative	24 nurses	Purposive	In-depth interviews	Nurses experienced role overload, psychological stress, and limited preparedness for mental health care during disasters. Despite challenges, they provided emotional support and reassurance, highlighting their essential but under-supported role in facilitating mental health access	Preparedness improves nursing response.
Veenema et al[7]	Examine nursing leadership	Identify disaster contributions	Disaster management	Community and hospitals	USA	Mixed-methods	146 nurses	Stratified	Survey and interviews	Nurses contributed to leadership, triage, and psychosocial support during disasters. Limited training in disaster mental health reduced confidence. Organizational support and interdisciplinary collaboration improved nurses' capacity to enhance service accessibility.	Leadership training strengthens disaster response.
Pfefferbaum and North[9]	Analyze pandemic mental health	Inform emergency response	Disaster psychiatry	Population-level	Global	Narrative review	30 studies	Narrative	Literature synthesis	Widespread psychological distress occurred during COVID-19, with disrupted access to services. Nurses served as key frontline providers of psychosocial care when specialist services were unavailable, emphasizing integration of mental health into emergency healthcare delivery.	Integrated responses improve mental health access.

Continued.

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Reifels et al[12]	Clarify nursing disaster roles	Examine professional scope	Mental health nursing	Disaster response teams	Australia	Qualitative	19 mental health nurses	Purposive	Semi-structured interviews	Mental health nurses provided PFA, crisis counseling, and referral coordination. Barriers included limited resources and unclear policies. Participants emphasized need for structured frameworks to support nursing contributions to emergency mental health services.	Policy support enhances nursing roles.
Kavanagh et al[25]	Identify access barriers	Explore facilitators to care	Health services access	Community	Ireland	Cross-sectional	1,200 adults	Random	Survey	Stigma, service availability, and long waiting times were key barriers to accessing mental health care. Findings applicable to emergency settings, highlighting importance of accessible frontline providers, including nurses, to mitigate service gaps.	Addressing barriers improves access.
Ventevogel et al[13]	Improve humanitarian mental health	Examine service models	Humanitarian psychiatry	Refugee camps	Multi-country	Policy analysis	Program data	Document review	Policy synthesis	Integration of mental health into primary care improved access and continuity of services. Nurses played central role in delivering basic care, co ordinating referrals in humani-tarian emergencies where specialist services limited	Integrated models improve service reach.
Patel et al[15]	Review global mental health	Inform policy and practice	Global mental health	Global	Global	Commissio n report	Multi-source data	Expert consensus	Evidence synthesis	Report emphasized workforce shortages and inequitable access to mental health services in crisis settings. Task-sharing approaches involving nurses highlighted as essential strategies to close treatment gaps and enhance service accessibility	Task-sharing is vital for equity.
Jones et al[14]	Examine severe mental disorders	Assess emergency care needs	Disaster psychiatry	Conflict zones	Multi-country	Review	29 studies	Narrative	Literature synthesis	Individuals with severe mental disorders experienced high relapse risk during emergencies due to disrupted services. Nurses supported medication continuity, basic care, reducing hospitalization and improving access to ongoing treatment	Continuity of care prevents relapse.
Everly and Mitchell[16]	Describe crisis intervention model	Evaluate CISM	Crisis psychology	Emergency services	USA	Conceptual	Program reports	Narrative	Model analysis	Crisis intervention models demonstrated effectiveness in reducing acute stress. Nurses trained in crisis management contributed to early identification and referral of individuals requiring advanced mental health support.	Early intervention reduces distress.

Continued.

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Hooper et al[17]	Assess compassion fatigue	Examine nurse wellbeing	Occupational health	Emergency department	USA	Cross-sectional	230 emergency nurses	Convenience	Survey	Compassion fatigue, burnout prevalent among emergency nurses. Psychological distress affected care delivery capacity, emphasizing need for mental health support systems for nurses during disaster response.	Supporting nurses sustains care quality.
Al Harthi et al[18]	Assess disaster preparedness	Evaluate nursing readiness	Disaster nursing	Hospitals	Saudi Arabia	Scoping review	45 studies	Systematic	Scoping synthesis	Preparedness levels varied widely among nurses. Lack of mental health training limited effective response. Structured education programs improved confidence and service delivery during emergencies.	Education improves preparedness.
Tol and Jordans[21]	Review child resilience	Identify protective factors	Child mental health	Conflict areas	Global	Review	37 studies	Narrative	Thematic synthesis	Community-based psychosocial support reduced distress among children in emergencies. Nurses contributed to family-focused interventions and early identification of mental health needs	Community support promotes resilience.
Ager et al[20]	Evaluate child-friendly spaces	Assess psychosocial impact	Child psychosocial care	Humanitarian camps	Multi-country	Program evaluation	11 programs	Purposive	Mixed-methods	Child-friendly spaces improved emotional wellbeing and social functioning. Nurses supported implementation and referral, enhancing access to psychosocial services in humanitarian emergencies.	Structured spaces support child wellbeing.
Epping-Jordan et al[22]	Test stress intervention	Evaluate SH+	Psychological intervention	Refugee camps	Multi-country	Randomized trial	694 adults	Random	Controlled trial	Intervention significantly reduced stress and improved functioning. Delivery by trained non-specialists under supervision shows feasibility and scalability, supporting nurse-supervised task-sharing models in emergencies	Scalable interventions improve access.
Galea et al[23]	Review PTSD epidemiology	Identify risk factors	Disaster epidemiology	Disaster sites	USA	Review	35 studies	Narrative	Literature synthesis	PTSD prevalence increased following disasters, particularly with high exposure and limited support. Early access to psychosocial care, often delivered by nurses, reduced long-term morbidity.	Early care reduces PTSD burden.
Ben-Ezra et al[24]	Assess pandemic distress	Examine nurse mental health	Occupational mental health	Hospitals	Israel	Cross-sectional	712 nurses	Convenience	Online survey	Nurses reported high anxiety and depressive symptoms during COVID. Psychological support availability influenced coping, reinforcing need for accessible mental health services for healthcare workers in emergencies.	Mental health support aids resilience.

Continued.

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Hyndman and Giles[32]	Examine gendered impacts	Explore displacement effects	Social determinants	Refugee settings	Global	Qualitative	38 displaced women	Purposive	Interviews	Displaced women experienced compounded psychological distress due to the gendered vulnerabilities. The community-based nursing support improved trust and facilitated access to psychosocial services.	Gender-sensitive care improves access.
UNHCR[34]	Provide MHPSS guidance	Strengthen refugee care	Humanitarian policy	Refugee operations	Global	Guideline	Program data	Expert consensus	Guideline synthesis	Guidelines emphasized integration of mental health into primary care and highlighted nurses as essential providers of the frontline psychosocial support as well as the referral coordination in the refugee emergencies.	Policy guidance strengthens service delivery.
WHO[35]	Rebuild mental health systems	Improve post-emergency care	Health system strengthening	Post-conflict	Multi-country	Policy report	Case studies	Document review	Comparative analysis	Integration of mental health into general healthcare improved service sustainability. Nurses ensured continuity of care and reduced relapse in the post-emergency contexts.	Integration improves sustainability.
Saxena et al[31]	Review global action plan	Guide mental health policy	Mental health policy	Global	Global	Policy analysis	Global datasets	Expert review	Policy synthesis	Workforce development, including nursing capacity building, was identified as a cornerstone for improving access to mental health services during and after the emergencies.	Workforce investment is essential.
Kakuma et al[28]	Examine HR challenges	Identify workforce gaps	Human resources	Low-resource settings	Global	Review	54 studies	Narrative	Literature synthesis	Severe shortages of mental health professionals were reported. Task-sharing with nurses emerged as a viable strategy to expand access during emergencies and humanitarian crises.	Task-sharing reduces treatment gaps.
Peek et al[29]	Examine children in disasters	Identify service needs	Child disaster health	Disaster zones	USA	Review	40 studies	Narrative	Synthesis	Children experienced significant psychological impacts following disasters. Nurses contributed to screening, family education, as well as the referral, enhancing early access to mental health services.	Early intervention supports child recovery.

Continued.

Authors	Objective	Purpose	Domain	Setting/ area	Country	Research design	Sample and population	Sampling technique	Methods	Results (50–60 words)	Conclusion
Roberts et al[33]	Assess early interventions	Evaluate trauma care	Trauma psychology	Disaster settings	Global	Systematic review	25 trials	Systematic	Evidence synthesis	Early psychological interventions reduced acute stress symptoms. Nurses trained in trauma-informed care supported timely delivery and referral, improving access to the mental health services after the disasters.	Early intervention is beneficial.
Shultz and Forbe[47]	Review PFA evidence	Assess intervention utility	PFA	Disaster response	Global	Review	28 studies	Narrative	Literature synthesis	PFA reduced acute distress As well as the promoted coping. Nurses were effective PFA providers in disaster settings due to accessibility and trust, supporting widespread implementation.	PFA enhances early mental health access.
Miller et al[58]	Assess preparedness	Examine HCW readiness	Disaster preparedness	Hospitals	Saudi Arabia	Cross-sectional	402 nurses	Random	Survey	Preparedness levels were moderate, with gaps in mental health competencies. Targeted training improved confidence and willingness to provide the psychosocial support during the emergencies.	Training strengthens preparedness.
Uddin et al[60]	Explore climate-related impacts	Examine psychiatric nursing role	Environ-mental mental health	Disaster-prone regions	Bangla-desh	Qualitative	22 psychiatric nurses	Purposive	Interviews	Nurses reported increasing climate-related mental health needs and emphasized community engagement and early intervention to the improve access during the environmental disasters.	Nurses are key in climate emergencies.
North and Pfefferbaum[2,7]	Review disaster mental health	Inform response strategies	Disaster psychiatry	Community	USA	Review	33 studies	Narrative	Synthesis	Community-based mental health responses reduced long-term morbidity. Nurses facilitated outreach, screening, and referral, improving access to services following disasters	Community approaches improve outcomes.

Evidence on outcomes: what works and where evidence is limited

The literature contains multiple descriptive and programmatic reports suggesting that nurse-driven MHPSS components (PFA, screening, medication continuity, referral coordination, and training/supervision of non-specialists) increase reach and short-term access indicators (e.g., number of people assessed/treated, referral completion). However, high-quality experimental evidence demonstrating long-term clinical outcomes attributable to nursing-led interventions in disaster contexts is sparse.[45] Many studies are limited by small samples, observational designs, or lack of control groups. Qualitative studies robustly document perceived value and feasibility of nurse roles but cannot quantify effect sizes.[46]

Quality of evidence and methodological observations

Quality appraisal across studies found a preponderance of descriptive and qualitative work, moderate-quality program evaluations, and relatively few randomized or controlled studies. Common methodological limitations included lack of baseline data, short follow-up periods, limited use of validated outcome measures, and inconsistent reporting of implementation fidelity. This heterogeneity underscores the value of integrative synthesis but limits causal inference about effectiveness.[47]

Illustrative case examples

Illustrative case examples further demonstrate how nurses adapted their roles across diverse emergency contexts to enhance access to mental health services. In post-flood shelter settings, nurses trained in PFA and basic mental health screening provided immediate psychosocial support, identified individuals with severe symptoms, and facilitated timely referral to mobile psychiatric teams, thereby reducing acute distress and ensuring continuity of psychotropic medication for people with severe mental illness. In conflict-affected outpatient clinics, psychiatric nurses supervised community-based case-finding and delivered brief psychosocial interventions, which improved service coverage in rural and insecure areas where specialist access was limited. During pandemic responses, general nurses, working under mental health supervision, implemented telephone-based follow-up and remote counseling, sustaining continuity of care and patient engagement when face-to-face services were restricted.[48] Collectively, these examples highlight the flexibility of nursing roles and demonstrate how nurses leveraged community structures, outreach models, and alternative care modalities to maintain and expand access to mental health services during emergencies.[49]

DISCUSSION

This integrative review synthesizes heterogeneous evidence showing that nurses are central to ensuring access to mental health services during catastrophes and emergencies. Nurses undertake pivotal roles-immediate psychosocial support (PFA), screening and triage, medication continuity, care coordination, group interventions, supervision of non-specialists, and leadership in planning-all of which can reduce treatment gaps when operationalized effectively. However, persistent system-level, provider-level, and patient-level barriers constrain the reach and effectiveness of nursing contributions. The collective evidence supports the strategic inclusion of nursing capacity in MHPSS planning, but rigorous evaluation of impact on clinical outcomes is limited.[50]

The findings align with global MHPSS guidance advocating for layered care and task-shifting to non-specialists in emergencies.[51] Nursing roles map naturally onto the lower and middle layers of the care pyramid (basic services, community and family supports, and focused non-specialist interventions), providing an accessible workforce base for scaling MHPSS. Prior reviews of disaster nursing emphasize the multifaceted clinical and non-clinical responsibilities of nurses and document workforce challenges such as limited training, psychological burden, and leadership gaps-themes mirrored in this review.[52]

Where this review adds specificity is in mapping nurse roles directly to access outcomes and in categorizing barriers and facilitators that most strongly mediate service reach. For example, linking medication continuity roles to relapse prevention illustrates how nursing activities can prevent adverse outcomes beyond immediate psychological distress. Similarly, the documented impact of nurse-led supervision on sustainability of community psychosocial programs highlights nurses' multiplicative effect on service capacity. Yet, the paucity of controlled outcome research leaves open questions about the magnitude and durability of these effects across contexts.[53]

Several policy and practice implications emerge from the evidence to strengthen access to mental health services during catastrophes and emergencies. MHPSS and nursing roles should be explicitly integrated into emergency preparedness plans, with clearly defined nursing responsibilities, pre-deployment training in PFA and basic psychosocial interventions, and well-established referral pathways embedded within emergency logistics systems.[54] Investment in nursing education and supervision models is essential; both pre-service and in-service programs should equip generalist nurses with competencies in brief psychological interventions, mental health screening, medication management in disrupted care settings, and supervisory skills to mentor community-based workers, supported by ongoing supervision from mental health specialists through in-person or remote mechanisms.[55] Ensuring continuity of psychotropic medication supply is also critical, with resilient supply-chain strategies prioritizing availability for individuals with severe mental illness and nurses playing a central role in medication reconciliation, monitoring, and patient counselling.[56] In

parallel, policies must address nurse wellbeing by implementing peer-support systems, rotation and rest policies, access to psychosocial services for responders, and organizational measures to mitigate burnout, recognizing that a psychologically healthy nursing workforce is fundamental to sustained service delivery.[57] Finally, promoting integrated, community-based models of care and expanding telehealth modalities where feasible-such as collocating mental health services within primary care and emergency settings-can reduce stigma, overcome logistical barriers, and enable nurse-led continuity of care when face-to-face services are limited.[58-60]

Research implications and evidence gaps

Key research priorities identified in this review underscore the need to strengthen the evidence base for nursing contributions to mental health service delivery during catastrophes and emergencies. Rigorous evaluations of nurse-led interventions are required, including the use of cluster-randomized trials, stepped-wedge designs, and interrupted time-series analyses in disaster-prone settings, to robustly assess their impact on service access indicators such as service uptake and waiting times, as well as on clinical outcomes and cost-effectiveness. Implementation research should also be prioritized to examine issues of fidelity, scalability, and sustainability, with particular attention to identifying optimal supervision models, training curricula, and task-sharing configurations that support effective service delivery. In addition, equity-focused research is essential; disaggregated analyses by age, gender, disability, and displacement status are needed to elucidate differential barriers to access and to inform the design of targeted, inclusive interventions. Finally, there is a critical need for longitudinal research examining long-term outcomes among individuals receiving nurse-led MHPSS, including relapse rates, functional recovery, and social reintegration, to better understand sustained impact of these interventions beyond the acute emergency phase.

Strengths and limitations of this review

Strengths of this review include a broad, inclusive search strategy across multiple databases and organizational platforms, use of integrative methods allowing cross-design synthesis, and focused attention on access-related outcomes and practical implications for nursing practice. Limitations include language restriction to English, potential publication bias (program successes may be preferentially reported), and heterogeneity of included studies that limited meta-analytic synthesis. The variable methodological quality of primary studies also constrains causal inferences about effectiveness.

CONCLUSION

This integrative review highlights the central and multifaceted role of nurses in facilitating access to mental health services during catastrophes and emergencies, where health systems are frequently disrupted and specialist mental health resources are scarce. Across diverse emergency contexts-including natural disasters, armed conflicts, and public health crises-nurses consistently emerged as the most accessible and trusted health professionals, providing essential MHPSS through PFA, screening and early identification, referral coordination, medication continuity, community outreach, and supervision of non-specialist workers. These roles positioned nurses as critical connectors between affected populations and formal mental health systems, thereby mitigating treatment gaps during periods of acute need. Despite their substantial contributions, this review identified persistent and interrelated barriers that constrain the effectiveness of nursing-led mental health service delivery. System-level challenges such as infrastructure damage, workforce shortages, medication supply disruptions, and limited integration of MHPSS into emergency preparedness frameworks continue to impede access. At the provider level, insufficient disaster-specific mental health training, unclear role delineation, occupational stress, and burnout reduce nurses' capacity to deliver sustained care. Patient- and community-level barriers-including stigma, cultural beliefs, displacement, and financial or logistical constraints-further compound inequities in access, particularly for vulnerable populations with severe or pre-existing mental health conditions. Collectively, these barriers contribute to underutilization of available services and delayed care, reinforcing the need for more resilient and inclusive emergency mental health systems. The review also identifies key facilitators that enhance access when effectively implemented. Pre-disaster preparedness training, task-sharing models supported by nurse-led supervision, mobile and outreach-based service delivery, integration of mental and physical health care, telehealth innovations, and culturally adapted, community-engaged approaches were associated with improved short-term outcomes, including reduced psychological distress and better linkage to services. These findings underscore the value of embedding nursing capacity within layered care models for emergency mental health response. In conclusion, strengthening access to mental health services during catastrophes and emergencies requires deliberate investment in nursing education, workforce wellbeing, policy integration, and system-level planning. Nurses should be formally recognized and supported as core providers within emergency MHPSS frameworks. Future research must prioritize rigorous evaluation of nurse-led interventions, equity-focused analyses, and long-term outcome studies to inform scalable, evidence-based models of care. By reinforcing nursing capacity and integrating mental health into emergency preparedness and response systems, health services can better address the psychological consequences of disasters and promote recovery and resilience among affected populations.

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