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Response to Letter to the Editor for 'Mental Health Problems in Traumatic Spinal Cord Injury Patients – An Umbrella Systematic Review'

Dear Editor,

We thank the correspondents for their thoughtful engagement with our umbrella systematic review[1] and for their generous appraisal of its methodological approach. Their letter raises three constructive points, namely the adult suicide risk, the maturing evidence base for digital interventions, and a sensitivity analysis around lower-quality reviews, each of which we welcome and address below.

We fully agree that suicidality warrants dedicated attention. In our synthesis, suicidal ideation surfaced most explicitly within the pediatric-onset cohort reported by Mofatteh et al,[2] where male sex, reduced motor function, and elevated depression levels were significant correlates. This reflected the distribution of the underlying systematic review literature rather than a judgment that suicide risk is confined to younger patients. The correspondents are correct that suicidal ideation and behaviour represent among the most consequential downstream sequelae of untreated mood disturbance in adults with spinal cord injury (SCI), and that functional impairment, chronic pain, and psychiatric comorbidity are recurrent correlates.[3] We also acknowledge the non-trivial contribution of self-inflicted injury to SCI aetiology.[4] Given our finding that fewer than 30% of patients with diagnosed mental health conditions receive active treatment,[1] we agree that adult suicide risk merits explicit incorporation as a discrete synthesis domain in future updates, and that suicide-specific screening instruments, rather than reliance on depression inventories alone, should be considered for embedding within rehabilitation pathways.

On digital and peer-led interventions, we concur that framing these solely as a future research direction understates an evidence base that is now emerging. At the time of our synthesis, intervention data across the included reviews were sparse and heterogeneous, which shaped our cautious positioning. The meta-analytic and scoping-review evidence the correspondents cite,[5] signalling improvements in quality of life and modest reductions in depressive symptoms via telemedicine, alongside a rapidly expanding landscape of internet-, mobile-, and cognitive behavioural therapy–based psychosocial programmes, is a valuable addition. We would qualify this only by noting the wide confidence intervals, modest pooled effect sizes, and methodological variability that characterise this early literature, which argue for measured optimism rather than premature translation into guidelines. With that caveat, we agree that a qualitative integration of this evidence would allow future overviews to reframe the conclusion from identifying a gap toward characterising a promising, if immature, evidence base, particularly relevant for resource-limited settings where scalable digital delivery may improve access.

Regarding the suggestion of a sensitivity analysis excluding the three reviews rated critically low on AMSTAR 2, we find this methodologically sound. As our study was a qualitative overview without pooled estimation, we prioritised higher-quality and more recent reviews in the narrative synthesis and transparently reported discordance, which partly mitigates the influence of weaker reviews. Nonetheless, a formal narrative comparison of findings with and without critically low-confidence reviews, especially for post-traumatic stress disorder and substance use disorders, where prevalence estimates were most variable, and study overlap contributed uncertainty, would strengthen readers' ability to gauge the robustness of those specific estimates. We will adopt this approach in any future iteration.

More broadly, these points reinforce a central message of our review that mental health assessment in traumatic SCI remains fragmented, that validated SCI-specific tools are inconsistently applied, and that the translation of screening into treatment is strikingly incomplete. Extending the synthesis to encompass adult suicide risk as an explicit domain and to

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characterise the emerging digital-intervention evidence would sharpen the clinical actionability of future overviews without altering their core conclusions.

We are grateful to the correspondents for these considered extensions, which we regard not as criticisms but as a shared effort to advance standardised, evidence-based psychological care for individuals with traumatic spinal cord injury.

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