of this evaluation was to identify whether CAARMS scores differ between patients diagnosed with autism and matched controls in York EIP.

Method. From their mental health records, we identified all patients in the service with a diagnosis of autism. We then compared the CAARMS scores, at the time of referral, to those of age matched controls (matched by being in the age range 16-30) without an autism diagnosis, using continuous sampling by date of referral.

Result. 14 patients in the service had a diagnosis of autism and had completed a CAARMS. CAARMS domains are all scored between 0 and 6 (indicating increasing severity or frequency). Compared to the age matched controls, autistic patients had a higher mean difference in their scores for 'Non-Bizarre Ideas' (mean difference of 0.86 for severity and 0.57 for frequency) and 'Disorganised Speech' (mean difference of 0.28 for severity and 0.57 for frequency). These results did not reach statistical significance which was unsurprising given the sample size. The gender split between groups was similar.

Conclusion. Our evaluation suggests a difference in CAARMS scores between patients in our service with a diagnosis of autism and those without. A larger study would be needed to confirm a statistically significant difference and multicentre results would be needed as evidence of generalisability. However, if such a difference were confirmed it might question the validity of CAARMS in autistic patients or suggest that modifications, perhaps in the form of reasonable adjustments to the questions or scoring, were needed to increase the validity in this population. We would suggest that spending extra time checking the patient has understood the intended meaning of the questions in the CAARMS may increase validity, particularly in the 'Non-Bizarre Ideas' domain.

COVID-19 pandemic moral injury in healthcare professionals: a systematic review

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Aims. Moral injury (MI) refers to psychological distress resulting from witnessing or participating in events which violate an individual's moral code. Originating from military experiences, the phenomenon also has relevance for healthcare professionals dealing with wars, natural disasters and infectious diseases. The deontological basis of medicine prioritises duty to the individual patient over duty to wider society. These values may place healthcare professionals at increased risk of moral injury, particularly in crisis contexts where they may be party to decisions to withdraw or divert care based on resource availability.

We conducted a systematic review of medical literature to understand the extent and clinical and socio-demographic correlates of moral injury during the COVID-19 pandemic.

Method. We conducted a systematic review of reports included in MEDLINE, PsycINFO, BNI, CINAHL, EMBASE, EMCARE and HMIC databases using search terms: "moral injury" AND "covid" OR "coronavirus" OR "pandemic". We also searched Google Scholar and Ovid Database and conducted reference searching. We searched for published quantitative primary research as well as advance online publications and pre-print research. Findings are reported in line with Preferred Reporting Items for Systematic Reviews and MetaAnalyses (PRISMA). Two authors independently assessed the included studies' methodological quality using a seven-item checklist.

Result. Our databases search identified 498 records and other sources identified 4 records. We screened 391 records after removing duplicates. 4 reports met our protocol requirements.

Three papers used cross-sectional designs. One reported longitudinal outcomes of their sample already described in one of the three papers. Only one study used a MI scoring system validated for healthcare professionals. Others used scoring validated in military populations. These papers reported outcomes from 3334 subjects, with a higher proportion of females. The largest study (3006 subjects) reported MI in 41.3% of their sample. Overall, factors associated with greater MI included: providing direct care to COVID-19 patients; sleep troubles; being unmarried; aged <30 years; female gender; and Buddhist/Taoist faith. Nurses reported a greater severity of MI than physicians. MI significantly correlated with anxiety, depression and burnout. The longitudinal study reported that more stressful and less supportive work environments predicted greater MI at 3 months follow-up.

The average quality assessment score of these studies was 4/7.

Conclusion. It is important that we are able to address moral injury awareness training as part of workforce preparedness and burnout prevention during the COVID-19 pandemic and other disaster responses across the globe.

Do Junior Doctors feel confident using Emergency Detention Certificates?

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Aims. To assess junior doctors understanding of the law surrounding the use of The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) with a focus on assessing confidence and knowledge of the use of the emergency detention certificate (EDC). A secondary aim was to use these findings to develop a variety of educational tools to subsequently improve junior doctors understanding in using the MHA.

Method. We created and distributed a comprehensive electronic survey to 152 Foundation Year Two Doctors working in NHS Lothian, Fife and Borders in December 2020. We subsequently interviewed 20 respondents to enquire about additional resources needed to improve knowledge of the MHA. Following on, we completed worked EDC exemplars, created an easily accessible guide with step-by-step instructions on implementing an EDC and devised a checklist pro-forma that can be accessed and inserted into a patient's electronic notes to ensure all necessary steps are completed for the EDC.

Result. 51 doctors (34%) responded to our survey, of which 10 (19%) had previously worked in psychiatry and 16 (31%) had previously completed an EDC. 27 respondents (52%) reported a lack of self-confidence and knowledge and 26 (51%) reported a lack of understanding in the legal processes as barriers faced when putting an EDC in place. 23 (45%) respondents were unaware that a Mental Health Officer (MHO) must be contacted to grant an EDC. Respondents who had experience of working in psychiatry reported greater awareness of the MHA. From the focused interviews held, colleagues requested for worked EDC examples, an easily accessible checklist with relevant contact details and an