not be managed safely with specialist support in the community. Little is known about how mental health legislation affects outcomes for people with intellectual disabilities and people with autism. For example, compulsory supervision under a Community Treatment Order, while not reducing admissions and readmissions,[8] can be seen as an aid in the promotion of engagement and adherence with treatment.[9] Future research should address this point as a priority.

In our view, there appears to be tension between the desire to reduce coercive treatment of people with intellectual disabilities and people with autism and the valid scepticism about the effect of the reform on access to care for many people with complex needs. Inpatient admissions might be needed for some and for longer than 28 days. Clinical experience indicates that lifelong difficulties, trauma, and comorbidities require careful assessments by multiple professionals. Without a clear understanding of aggressive challenging behaviour, the availability of evidence-based alternatives to admission, and measures for better ascertainment of mental ill health in people with comorbid developmental conditions and severe intellectual disability, the reforms might overpromise and underdeliver. We assert that this would disadvantage people with intellectual disabilities and people with autism and their carers in achieving equity in mental health-care provision.

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Moral injury: the effect on mental health and implications for treatment

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Moral injury is understood to be the strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code.[1] Potentially morally injurious events include a person's own or other people's acts of omission or commission, or betrayal by a trusted person in a high-stakes situation. For example, health-care staff working during the COVID-19 pandemic might experience moral injury because they perceive that they received inadequate protective equipment, or when their workload is such that they deliver care of a standard that falls well below what they would usually consider to be good enough.

Unlike post-traumatic stress disorder, which can occur following threat-based trauma, potentially morally injurious events do not necessarily involve a threat to life. Rather, morally injurious events threaten one's deeply held beliefs and trust. Moral injury is not considered a mental illness. However, an individual's experiences of potentially morally injurious events can cause profound feelings of shame and guilt, and alterations in cognitions and beliefs (eg, "I am a failure", "colleagues don't care about me"), as well as maladaptive coping responses (eg, substance misuse, social withdrawal, or self-destructive acts). It is these challenged beliefs and altered appraisals that are thought to lead to the development of mental health problems, with a 2018 meta-analysis finding that exposure to potentially morally injurious events was

significantly associated with post-traumatic stress disorder, depression, and suicidality.[2]

Although exposure to potentially morally injurious events, and the moral injuries that followed, were initially examined in military personnel in combat settings,[1] moral injury is not limited by occupation. Studies increasingly show many professionals are exposed to potentially morally injurious events and the risk of moral injury, including journalists, police, and veterinarians, as well as military personnel.[2] In the context of the COVID-19 pandemic, moral injury has been found to be one of the greatest challenges reported by UK National Health Service frontline health-care staff and is significantly associated with post-traumatic stress disorder and depression.[3,4] Moral injury was also reported to be a key cause of distress for journalists during their coverage of the 2015 migrant crisis.[5] Nonetheless, moral injury remains a difficult concept to measure objectively because existing tools often have methodological problems or are not validated for use in non-military populations.

Beyond the reported associations between potentially morally injurious events and mental health outcomes, studies have begun to examine what moral injury can mean for the person affected and how this type of experience can affect their daily functioning. Studies, largely from the USA, highlight how people with moral injury can undergo an existential crisis as a result of their experience.[6] Other studies show how moral injury can adversely affect the person's familial and occupational functioning, with many affected individuals reporting familial breakdown and unemployment due to their distress related to potentially morally injurious events and maladaptive coping responses.[7]

Taken together, the international literature indicates that moral injury might be an important public health concern. Yet, no validated treatment for moral injury currently exists. Treating patients whose mental health problems are caused by moral injuries can be challenging for clinicians. Firstly, exposure-based approaches could be unhelpful or even harmful in cases of moral injury if inadequate attention is paid to emotional processing of feelings of shame and guilt. Secondly, many commonly used evidence-based treatments for trauma-related mental health problems (eg, trauma-focused cognitive behavioural therapy) often involve cognitive restructuring of a patient's erroneous, pathological, or distorted appraisals and their replacement with new and more adaptive appraisals of the self or the event. Such methods might not be effective or appropriate when treating patients whose shame and guilt arise from commission of transgressive acts of perpetration, rather than from erroneous appraisals.[8] For example, with a prison officer who seriously injured a detainee with undue force, it might be futile at best, or increase the likelihood of future perpetration at worst, for a clinician to challenge their accurate appraisals of wrongdoing.

Approaches that focus on self-forgiveness, acceptance, self-compassion, and (if possible) making amends, might hold more promise. In cases in which the effects of moral injury extend beyond psychological to spiritual harms, spiritual care providers could have a role alongside mental health clinicians.[9] It is essential that clinicians who assess people exposed to potentially morally injurious events ask about moral injuries sensitively because otherwise patients might avoid talking about their experience or their altered beliefs for which they fear others might judge them.[7] In this regard, there is promising emerging evidence for some treatment approaches, such as adaptive disclosure and acceptance and commitment therapy, but these treatments have mainly been trialled in morally injured US military veterans.[8] As moral injury becomes increasingly recognised in other spheres, more evidence is needed to understand the extent of the problem across populations exposed to potentially morally injurious events and whether such treatment approaches are appropriate and effective for civilian, non-US populations. More consistent reporting of adverse events, treatment dropout, and long-term remission rates is needed for clinicians to be able to offer such treatments to patients with confidence.

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Choice of outcome measures in mental health research

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Measurements represent one of the most dysfunctional aspects of current mental health research. With so many measures in use and little consensus on their meaning, tangible clinical benefits of mental health research continue to largely elude our field. As we wrote in a recent Editorial,[1] developing a mental health science for the future necessitates substantial change. *The Lancet Psychiatry* will now therefore require authors of research Articles to provide a brief statement in their Methods section with the subheading "Choice of primary outcome measure". Here, we provide an explanation of what information we will request, and how we hope it will benefit authors, reviewers, and readers of our journal.

Within this new Methods subsection, we ask that authors briefly describe the following points: why they have chosen their primary outcome (including any information on psychometrics), how widely used their measure is for the population and the clinical question addressed in their manuscript, how accessible their primary measure is (which can include any information regarding payments or permissions needed, how lengthy or time-consuming implementation of the measure is, and whether the measure has been translated into other languages), and what the clinical meaning is of changes in the points measured using the score.

While our new requirement in no way restricts the measures authors can publish with us, our hope is that these additional details will provide authors with space to consider and contextualise their choice of primary measure.

We understand that no new formatting requirement is ever small or easy for authors who are balancing ever-increasing demands on their time, and we have tried to be mindful of this. But, we anticipate the additional effort we will be asking from authors will make it much easier for editors and reviewers to understand the reasoning and clinical meaning behind a manuscript's findings, making the assessment and peer-review process that much faster. Equally important, we hope this additional information will enable readers of Articles ultimately published with us to better grasp the implications of the findings.

Measurements in mental health research will continue to pose a challenge, but we hope this small step in *The Lancet Psychiatry* will help to expand the dialogue and inspire new efforts towards progress in developing a mental health science that can improve the lives of service users across the world.

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1 *Lancet Psychiatry*. A good enough measure. *Lancet Psychiatry* 2020; **7:** 825.