Rating Eating Disorders Using the Health of the Nation Outcome Scales (HoNOS) - Guidance and Vignette

The Health of the Nation Outcome Scales (HoNOS) Glossary contains few examples of the problems associated with eating disorders. The following guidance is to be used alongside the HoNOS Glossary to ensure better accuracy in rating the HoNOS with consumers who have eating disorders.

HoNOS Glossary Guidance

1. Overactive, aggressive, disruptive or agitated behaviour

Include physical restlessness, fidgeting, not being able to sit down, overactivity, pathological exercise (driven by ED psychopathology) and behaviours that disturb family life (e.g., not letting others eat/cook/store or prepare food freely in kitchen & intrusive exercise regimes), circadian shift (eating at night), temper tantrums, head banging, the consumer blocks plumbing, steals, etc.

2. Non-accidental self-injury

No ED specific guidance.

3. Problem-drinking or drug-taking

Include misuse of drugs/medicines that are associated with psychological/physical harm, addictive behaviour of the type associated with psychoactive substance misuse, and psychological/physical effects from withdrawal – examples include laxatives, thyroxine, caffeine, metabolic stimulants etc. Rationale – this type of drug/medicine misuse is rated here rather than in scale 2 (non-accidental injury) because these behaviours are habitual and addictive in quality. The types of interventions being offered more closely resemble those associated with substance misuse than deliberate self harm.

In clinical practice, some consumers will have both problems associated with drug or medicine misuse and deliberate self harm, while others may not, indicating the need for different types of interventions depending on their presentation. There is therefore clear clinical utility in separating the scoring of these different behaviours between scales 2 and 3.

4. Cognitive problems

Include those related to starvation, extreme rigidity and fixation on detail associated with obsessive compulsive personality disorder.

5. Physical illness or disability problems

Include markers of acute physical risk and chronic medical problems (such as osteoporosis). Consider physical problems arising from starvation, bingeing and purging and obesity (which may be a problem with bulimia nervosa and binge eating disorder).
BMI < 15 is considered severe
BMI > 35 severe.

6. Problems associated with hallucinations and delusions

Delusional thinking regarding body image should be considered here.

7. Problems with depressed mood

No ED specific guidance.

8. Other mental and behavioural problems

Include in G, Eating: fasting/food restriction (not including religious fasting), bingeing, vomiting.

9. Problems with relationships

Consider problems, or lack of relationships with family, friends, intimate relationships and rate the most severe problem.

10. Problems with activities of daily living

Include difficulties shopping, storing or preparing food. Inability to eat socially. The need to have supervised/supported eating. Rigid routines around eating.

11. Problems with living conditions

Include lack of facilities e.g., fridge, cooker.

Include family or friends accommodating and enabling symptoms by reassurance giving, “fat talk”, dieting behaviour, over protection, overly permissive, overly authoritarian, rigid e.g. give money for binges, turning a blind eye to unacceptable behaviours etc.

12. Problems with occupation and activities

Include toxic work environments such as ballet, modelling, acting, food outlets, jockeys etc, and those that support or encourage over working and an inability to allow leisure time.

Eating Disorders Vignette

Jessica is a 19 year old university student referred to community mental health services by her GP. She lives at home with her parents and 3 younger siblings. Jessica weighs 40 kilograms and at 160 cm tall has a Body Mass Index of 15.6. She is accompanied to the assessment by her mother. She states that she did not want to attend the interview, thinks there is nothing wrong with her and has come to "get my mother off my back". Although she is underweight with her ribs and back bone clearly visible through her clothes, Jessica says that she has never felt healthier or more confident. She says her mother is "old fashioned" and would prefer her to be a "chubby" – "she just doesn't get it; she's stuck in the 60s".

At interview she presents as well groomed, with makeup impeccably applied. Her hair is very fine and is tied back in a ponytail. As her hair is short, she has created the ponytail with a hair extension. She states that she feels calm and relaxed, but appears to be agitated and fidgety. She says she has a lot of energy, can't stay still and likes to keep moving. She chews gum throughout the interview and constantly drinks water. When asked about this she says it helps her quiet her stomach – "I'm always hungry, I'm a guts".

She says that until recently she would exercise for at least 2 hours each day to tone her figure and "be healthy". She started "getting healthy" 2 years ago, after she put on weight due to the stress of her HSC. "I used to be a comfort eater". However, since 3 weeks ago she has not been able to train as much because a single lap of the field during training makes her dizzy and she gets cramps in her legs and stomach. She says she has had a lot of colds and other "bugs" lately. She says that she has turned to laxatives and 'no doze' caffeine tablets to help manage her weight as she does not want to get fat while she waits to "recover from the bugs". She started off taking one laxative and one 'no doze' a day, but during the last 2 weeks has been taking 2-3 a day of each "to compensate for the reduced exercise". If she doesn't take them, she feels anxious and distressed and ruminates over her weight. She does not drink alcohol - she says it has too many calories. She denies drug use. She has not menstruated in 6 months. She says she is not worried about that as she has read that this happens to elite female athletes whose body fat is low.

She says she feels miserable, depressed and guilty when she eats too much. "Too much" for her includes eating <u>any</u> meat, fish, potatoes, pasta, rice or "fatty foods". She prefers to eat vegetables and salads. She denies suicidal ideation, hallucinations or delusional ideas. There is no evidence of cognitive deficits.

She stopped going to university 2 weeks ago because she couldn't stand other people seeing her when she was "not at her peak". She plans to go back in a couple of weeks when she feels better. For a similar reason she stopped doing temporary secretarial work. She says she needs to focus on her health and make that her top priority. When she feels better, she plans to up her exercise to 4 hours a day to "make up for lost time". Her father has offered her work in his business in the meantime, but she has declined.

Her mother voices her concerns over Jessica's obsession with food and exercise. Whereas "she used to be a lovely girl", she has become very secretive, irritable and argumentative. She has been

focusing on her weight to the exclusion of all else. She moves around constantly “to burn up calories”, which both concerns and annoys the family. They have sometimes heard her exercising in the middle of the night, with this disturbing their sleep. She has always been a self-motivated, above average student but as she has now stopped going to university they are worried that she may fail some of her classes. “She has lost touch with everyone, including her friends”, whom she has been actively avoiding when they drop by to visit. She has insisted that her mother tell them that she was asleep and could not be disturbed. She used to be involved in all sorts of social clubs and was a member of Rotary. She is no longer interested in these activities, as they “are no longer priorities”. Apart from the eating issue, her self-care is still adequate and she is still able to perform her chores such as making her bed, budgeting and driving herself around.