Returning the Not Guilty by Reason of Insanity to the Community: A New Scale to Determine Readiness

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The very difficult and very important decision on the readiness of an insanity acquittee for community treatment is often based on informal, invalidated criteria. A more standardized approach is needed. The bases for decisions can then be more clearly articulated and the adequacy of recommendations evaluated. This article describes the development of a scale designed to help guide decisions on readiness for community treatment.

In California, as in many states, the State Psychiatric Hospital is the primary provider of treatment and assessment for people found not guilty by reason of insanity (NGRI). A critical portion of the assessment task is the determination of a patient's readiness to return to community living. Decisions in this area must balance the civil rights of the patient with the safety needs of the community. In California, the final decision on a patient's readiness to leave the hospital is made in the courts. The hospital's role is to provide the court with information and recommendations that will help shape that decision in an informed and clinically sensitive way. It is hard to overestimate the importance of these hospital recommendations for the patient, the court, and the community.

Patients committed NGRI in California must be reviewed every six months to determine their continuing treatment needs. This review is done by the patient's treatment team, which consists of a physician or a psychiatrist, a social worker, a rehabilitation therapist, one or more members of the nursing staff, and a psychologist. Patients ready for community treatment are referred to the conditional release program in the county where originally found NGRI. Each county has a conditional release

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program, and it is these programs that are responsible for continuing the patient's supervision and treatment following release from the hospital. Patients that are accepted into conditional release programs will remain in the community only as long as they comply with the rules of the program and are not perceived as a danger to the community. In order to recommend a patient for community treatment, the patient's treatment team must state that the patient "will not be a danger to the health and safety of others"[1] while in the supervised community setting.

In spite of the chance for assessment in the hospital and the opportunity for supervision of NGRI patients, the results of the ambitious study by Lamb *et al.*[2] called into question the effectiveness of the California conditional release program. In an evaluation of the Los Angeles County program, they found a 32 percent rearrest rate for patients in community treatment, with 72 percent of those arrests (22% of the entire sample of 79) for violence against persons. Their study covers a five-year period, starting in January of 1981, and considers all patients accepted into community treatment after their first referral (patients accepted after two or more referrals were not included in the study). Overall, there was an approximately 30 percent rate of "unsuccessful outcome" at the end of five years. Lamb *et al.*[2] determined that much of this unsuccessful outcome was due to difficulty in adequately screening patients for participation in the program.

Perhaps in anticipation of the Lamb *et al.*[2] data, or as newly established programs have self-corrected, rates of reoffense during community treatment in all counties in California have dropped considerably. Wiederanders (unpublished paper presented at the meeting of the Forensic Mental health Association of California, March 1988) reported a 3 percent rearrest rate for violent reoffense in a one-year follow-up of 500 patients participating in conditional release programs throughout the State of California. Studies conducted in other states yielded similar results. Bloom *et al.*[3] reported a 4 percent rate of felony rearrest during outpatient treatment for a group of 91 during a three-year follow-up. Cavanaugh and Wasyliw[4] reported no felony rearrests during a two-year follow-up of 44 NGRI patients participating in a conditional release program. For comparison, Monahan[5] suggested a 10.5 percent rate of violent crime among released prisoners. Pasewark *et al.*[6] reported a 22 percent felony rearrest rate over a five-year period for 133 NGRI acquittees released in New York with little or no supervision.

Currently, at Patton Hospital, most revocations from conditional release status are due to violations of a program's provisions, such as failure to attend appointments, use of illicit drugs, failure to take medication, or substantial return of illness. This is similar to the experiences reported by Bloom *et al.*,[3] and by Cavanaugh and Wasyliw.[4] Through effective supervision, the programs can become aware of symptoms or behaviors that create the potential for dangerousness, justifying a return to a more secure

environment. This results in low rates of dangerous behavior while in community treatment.

What, if anything, do the hospital's recommendations contribute to that outcome? Can improved recommendations improve other indices of successful outcome? These questions can only be answered by taking a systematic look at the decision-making process.

The decision to make a recommendation for community treatment is currently based on mixed groups of informal criteria. Each interdisciplinary team forms its own norms based on the experience of the individual team members. Teams can have widely different perspectives on readiness for community treatment, in part due to the members' training, management issues, and treatment populations to which they have been exposed. This leads to inconsistency among the decisions made by various teams, and can have an undermining effect on recommendations when they are reviewed by courts and conditional release programs.

While treatment teams may emphasize different issues when making decisions, there are a number of common factors considered when evaluating a patient's readiness to move into community treatment. For example, it is unlikely that any team would recommend a patient who becomes psychotic and violent when not using medication and tries to avoid taking medications while in the hospital. A person who resents medications but takes them with supervision and develops psychotic symptomatology slowly when off medication would be a better bet, and a person who shows strong motivation to take medication and maintains a solid remission with those medications is the most likely to receive a community treatment recommendation. Similar observations can be made about issues of self-control, participation in treatment, awareness of treatment needs, abuse of substances, and so on. In fact, when guidelines have been generated by other agencies involved in the decision-making, similar criteria are mentioned repeatedly.

Readiness for community treatment is related to a patient's performance in a number of different areas that are relevant to the strengths and limitations of the community treatment programs. The assertion that a person will not be dangerous while in a conditional release setting, that the person is "ready" or "supervisable", is made when an acceptable level of progress is made in a number of areas. While many decision-makers use similar criteria to determine readiness, these criteria have not been organized, applied, or evaluated in a systematic way. The purpose of the work presented here was to specify all criteria thought useful in evaluating readiness for community treatment.

Development of the Scale

Rationale Before developing a scale to measure readiness for community treatment, consideration was given to the use of existing clinical measures. The Minnesota Multiphasic Personality Inventory (MMPI) and Rorschach tests,

for example, both provide information that can be useful in the prediction of dangerousness (see for example, Maloney[7]), but there is no published work showing their usefulness in predicting readiness for community treatment. Some conditional release programs use one or another of these instruments to guide their decisions when evaluating patients for acceptance into their programs. However, the information that they provide is often minimal compared to the years of observational data that has already been collected by the multidisciplinary treatment team. What is needed is a tool that would organize and weight all of the information that has been gathered.

It was decided that it would be most effective to design an instrument to meet the hospital's specific needs. In addition to being a test of what is considered to be important to readiness for community treatment, it could also serve as a staff-training tool, and help provide an outline for treatment. Information on the reasons that people are revoked from community placement could be incorporated directly into the instrument.

All of these features were incorporated into the final "Guidelines for Community Outpatient Treatment (COT) Readiness" (see Appendix), which began as a program-wide brainstorming session. Members of all disciplines contributed their ideas on what patients should be like when they are ready to leave the hospital. These ideas were clarified and organized into 16 different items. Then, thinking of many patients at different levels of progress, five descriptive points for each item were generated. In its final form, the scale has 15 items which group roughly into three categories: degree of illness and self-control, awareness and concern about illness and its consequences, and coping strategies for now and the future.

Description

The scale was intended for use by any individual involved in the community-treatment decision-making process. The items cover issues that are commonly considered important to readiness, and can be used as an outline for a comprehensive interview. Each item's five descriptive points carry a substantial amount of information. This improves consistency in scoring, while communicating important information to interviewers who may have limited experience. Proper completion of the scale requires a comprehensive gathering of information from the patient, staff, and record; an essential process for good decision making. The completed scale can form the basis of a report on the final decision.

Each of the 15 items of the scale are scored from 1–5, using the descriptive anchors for guidance. Lower numbers indicate increasing achievement. All items must be completed, and a score of 1 is assigned when an item does not apply. It is not yet possible to make assumptions about the predictive value of the scale as a whole or of combinations of items, and cut-off scores for predicting readiness have not been set.

Any cut-off score that may be applied

will have to be adjusted for type of community placement, the less restrictive placement perhaps requiring a lower score. Weighting of individual items will probably have to respond to a number of factors specific to each individual case, such as diagnosis and degree of illness. The predictive usefulness of the scale will be determined by future research.

The following is a brief overview of the items on the scale. The entire scale can be found in the Appendix.

Item 1: Illness It is best for patients to show a longstanding remission of symptoms that does not break down under stress. Many patients, for example those with chronic illness and long term drug abusers, will not show a full remission of symptoms. If the continued illness will not be problematic in the proposed setting, then these individuals can be good candidates for outpatient treatment.

Item 2: Behavior In order to be successful in community placement, a patient must be able to get along with others and accept structure imposed by program personnel. Behavior problems can also act as a signal of continued illness. This item screens for individuals with substantial problems in this area without heavily penalizing those with less serious but persistent problems in adapting to the hospital environment.

Item 3: Substance abuse This is a crucial item for many patients and may receive emphasis by reviewers. It is difficult to know if any real change of patterns of abuse have occurred while an individual is hospitalized. This item suggests a number of clues that may be helpful in determining if change has occurred. Score 1 if substance abuse has not been identified as a problem.

Item 4: Treatment attendance This item emphasizes attempts to use treatment productively, not progress. Treatment participation provides a degree of external control, while motivation for treatment offers evidence of an individual's commitment to change.

Item 5: Medication When medication is necessary, active involvement with it through consultation with the physician, awareness of side effects, and knowledge of function of medications, implies better compliance and more successful outcome. Score 1 if not taking medication.

Item 6: Self-awareness This item addresses what is often referred to as "insight." The item attempts to make the term more concrete, while keeping the focus on crime and illness. Behavior is also emphasized.

Item 7: Signs of illness. Item 9: Concern about becoming ill. Item 10: Plans for reemergence of illness Since, for these patients, illness was a primary cause of dangerous behavior, recognizing and responding appropriately to illness is extremely important. Several items address this directly. Item 7 asks the patient to play a major role in the

early detection of illness. Item 9 asks that the patient know the potential danger of becoming ill, and item 10 requires adequate plans for coping with illness if it recurs. These items appear to be particularly sensitive to future treatment environment. Less structured settings will require considerably more progress in these areas.

Item 8: Lifestyle adjustment Environmental stress plays an extremely important role in the recurrence of illness. This item addresses the patient's ability to recognize stress and its causes, and make changes that will keep stressors under control.

Item 11: Relationship of illness to crime This item is an important adjunct to the items on recognizing illness. The various motivations to avoid illness that are suggested in this item are indicators of internal control.

Item 12: Acceptance of responsibility for crime Accepting responsibility can act as a cornerstone for change, a sign that change has occurred, or a motivating factor in the avoidance of future problems. As a measure of acceptance of responsibility, this item asks that the patient be willing to talk about the crime in detail. Affective response to the material is expected, but the nature and timing of that response can be quite varied.

Item 13: Need to continue treatment In recognition of the often cyclic nature of mental illness, it is important for patients to continue contact with a mental health support system for an extended period. Continued treatment is also necessary because many issues of daily living can not be addressed in the relative isolation of the hospital setting.

Item 14: Future plans Working toward personally satisfying, achievable goals can have a positive influence on posthospital adjustment.

Item 15: Accepts COT restrictions Most revocations of community treatment status are due to breaking program rules. The ability to understand and adjust creatively to the rules is an important determinant of success in community treatment.

Conclusions

Deciding when to release a patient whose confinement is based on short-term predictions of dangerousness is, according to Alan A. Stone[8] "the most pressing clinical problem in psychiatry today." To solve that problem, it is necessary to shift our thinking from the prediction of dangerousness to the prediction of nondangerousness.[9]

Readiness for community outpatient treatment is a decision based on nondangerousness. While borrowing from current thinking on the prediction of dangerousness, making tenative rather than absolute predictions for specific time periods, in specific settings, and using a combination of clinical and statistical models,[7,5,10,11] the techniques of prediction need to be tailored to the

demands of the prediction being made. Perhaps it would be better to call the readiness decision a prediction of "supervisability" to distinguish it from other types of decisions that, for example, rely more heavily on demographics and history. Supervisable patients can be guided to avoid dangerousness or intercepted before acting in a dangerous manner. Supervisability derives from an interaction between patient and program characteristics.

There is great need for a scale that identifies the factors that are useful in deciding which judicially committed patients are ready to enter community placement, and which has the potential to contribute a quantifiable component to the decision-making process. Too often we hear comments such as "I wouldn't want him living in my neighborhood", "I'm not comfortable with the amount of color on the Rorschach", or "I'll know it when I see it" playing roles of undetermined importance in the decision-making process. At other times, when more objective-sounding criteria are offered, there is no way of weighing them, viewing them in context for a particular individual, or knowing if they have any general usefulness at all in predicting readiness for community treatment.

To highlight this problem, consider the following findings. Steadman and Morrissey[12] concluded that, for a sample of 282 judicially-committed State hospital patients in New York, hospital assaultiveness had no statistical relationship to later assaultiveness in the community. For Cavanaugh and Wasyliw's[4] sample of 44 NGRI patients followed in a conditional release program for two years, MMPI Psychopathic Deviate scores in the diagnostic range were not predictive of subsequent offense. Finally, both Cavanaugh and Wasyliw,[4] and Wiederanders (unpublished paper previously cited) found inverse relationships between seriousness of original NGRI offense and likelihood of rehospitalization or rearrest. Common sense alone appears to have little to offer those who are guessing about low base rate behaviors. Rates of revocation of community treatment status are reported as high as 51% (see, for example, Bloom *et al.*[3]). This is also, to some degree, a reflection of how difficult it is to make good readiness decisions.

The lack of clearly articulated criteria for making readiness decisions results in considerable frustration for those who treat, those who evaluate, and for those members of the legal profession who have ultimate decision-making authority. For the patients, it is a tremendous source of stress. Many patients view hospitalization as an indeterminate sentence with vague, unknowable, or capricious rules for parole. The general goals of hospital treatment are often too abstract for many of our patients who want to know, specifically, what they have to do in order to leave the hospital.

The Guidelines for COT Readiness scale is a step in the direction of clarifying and objectifying the decision-making process. An evaluation of the scale's statistical characteristics is underway, and future work will determine if total scores, scores for combinations of items,

or some form of weighting for each individual patient can be useful in predicting success in community placement. Positive results would represent significant progress toward the goal of developing a set of clearly defined criteria that contribute meaningfully to the prediction of readiness for community treatment.

Appendix

Guidlines for COT Readiness (this scale is for experimental purposes only)

1. Illness

1. No signs of illness for at least six months. Remission appears durable.

2. No signs of illness for at least three months, or continued minimal predisposing factors (occasional depression, significant family conflicts when patient *not* planning to return to parents).

3. Continued residual signs of illness that won't interfere in proposed life style (occasional, benign hallucinations, moderate social isolation or signs of poor judgment, moderate authority conflicts). Also individuals with predictable, readily recognizable, slowly developing repeated decompensations.

4. Episode of active illness brought under control within last three months. More pronounced residual signs (more open suspiciousness, frequent authority conflicts, nonorganic problems with concentration). Also individuals who may remain stable for at least six months, but have sudden unpredictable onset of illness. Fragile remissions.

5. Actively ill or unpedictable, readily developing recurrent episodes of illness.

2. Behavior

1. Follows unit routine without problem. Contributes actively and energetically to maintenance of unit. Strives to participate in Ward Government and community meetings. No rule-breaking on grounds. (This category applies to actively involved patients, not those who avoid problems because of passivity.) Conflicts with staff and peers handled constructively.

2. Follows rules on and off unit. Does assigned tasks and follows directions without undue complaint. Conflicts with staff and peers are minimal and generally avoided by using good judgment and forebearance.

3. Minor staff and patient conflicts occur on a regular basis, patient accepts partial responsibility. Minor rule-breaking and testing the limits with appropriate response to structuring and discipline.

4. Minor patient and staff conflicts occur regularly and patient will *not* accept responsibility or resists structuring and discipline. Single major episode of acting out within last six months. Strong resistance to unit routine or rules without major acting out.

5. Repeated major incidents of rule-breaking or acting out. Behavior suggests general unwillingness or inability to conform.

3. Substance Abuse

1. Convincing awareness of how drug use is or can be connected to mental

illness. Active, motivated participation in AA and/or NA. Negative monthly drug screens for six months. Avoids drug users, sellers.

2. Knows relationship between drug use and mental illness. Good attendance in AA and NA, adequate participation. Negative monthly drug screens for at least six months. Avoids drug users and sellers.

3. Aware of danger potential of drugs but minimizes importance of use of marijuana and/or alcohol. Limited participation in AA and/or NA, although attendance is adequate. May have friends who use or sell drugs.

4. Minimal participation and poor attendance in AA and/or NA. May pay lip service to relationship of drug use to illness but no real commitment to idea. Resists drug screen procedure.

5). Strongly suspected or confirmed drug use in past six months. Strong resistance to participation in NA and/or AA. Does not recognize the importance of abstinence.

4. Attends Treatment

1. Rarely, if ever, misses treatment activities. Actively participates and to best of ability tries to understand self and illness. Knows and understands problem list and makes efforts to relate issues to life and address them in treatment. May pursue reading and family therapy on own.

2. Attends therapy regularly. Talks about self and crime and is willing to consider therapist's perspective on illness. Does recommended exercises.

3. Misses occasionally but cooperates when present. May have difficulty speaking seriously about self, and may become bored when others are speaking. Invested in appearing "well" and resists looking at self from new perspective.

4. Misses group regularly or frequently leaves early. Strongly invested in appearing "well" and contributions center only on how well patient is doing. May argue with therapist or try to focus on irrelevant issues, such as injustices perpetrated by staff. Resists treatment planning process.

5. Refuses group, or attends very sporadically or only for short time. Hostile to treatment planning process. If attends group, uses as an opportunity to lecture, showing no interest in self-exploration.

5. Medication

1. Takes medication willingly. Knows type, dosage, and function. Consults productively and actively with physician regarding medication. Accepts side effects, including restructuring of activities. (Also score 1 if no medication for last six months.)

2. Takes medication regularly. Knows type, dosage, and function. Cooperates in medication review. Accepts side effects.

3. Takes medication regularly. Knows medication name and function. Does not express resentment, although not adjusted to side effects.

4. Takes medication but regularly needs reminder. Knows only general function of medication. Resents side effects. Talks about being medication-free after leaving hospital.

5. Needs frequent reminder and "mouth check" to be sure medications are taken. Does not know medication

name, dosage, or function. Very uncomfortable with side effects or need to take medications.

6. Self-Awareness (Treatment Plan Process)

1. Through hospital experiences, has developed a deep awareness of needs, motivation, emotional and behavioral responses, interpersonal style, interests, family conflicts, coping style, strengths, limitations. Has carefully considered areas of significant conflict and demonstrated change which has led to substantially more effective observable or easily elicited behavior.

2. Has explored above areas and recognizes the importance of continued self-exploration, although may still lack substantial self-awareness. Has, however, thoroughly explored areas directly related to crime and illness and demonstrates change leading to change in observable behavior.

3. Willing to consider self, as above, but requires much work to do so. With help explores significant areas related to crime and illness, with some behavioral change.

4. Considers above areas with help. Has difficulty seeing importance of general self-exploration. Has considered significant areas related to crime but behavioral change is minimal or fragile.

5. Resists self-exploration. Very threatened by suggestion of need to change. Talks about crime but little change in thinking or behavior, or only superficial change.

7. Understands Signs of Illness

1. Can describe own active illness in full detail. Can describe at least six significant early and middle signs of illness, recognize their presence in own original and later occurring illness.

2. Knows prominent features of own illness. Can give good description of several important early and middle warning signs and can give examples from illnesses.

3. Can identify one or two prominent features of own illness. Speaks generally about warning signs but can't identify in own illness.

4. Knows general prominent features and warning signals of illness but much difficulty relating to own illness.

5. Vague notions of mental illness. Little awareness of own illness. Rote repetition of general signs and warning signals.

8. Life Style Adjustment

1. Can specify environmental stressors that contributed to illness. Can specify dysfunctional patterns of thinking, feeling, and responding that magnified environmental stressors. Demonstrates competence in handling probable stressors. Demonstrates change in dysfunctional patterns of thinking, feeling, responding. Future plans realistically address relevant stressors originating in family, work, etc.

2. Identifies and has worked to change at least one prominent environmental factor. One clear change in at least one dysfunctional pattern relevant to illness. Demonstrated competence in handling probable stressors. Future plans may be vague but generally acknowledge potential environmental and internal stressors.

3. Identifies significant environmen-

tal stressors but needs help with restructuring, although responds favorably to guidance. Showing change in dysfunctional patterns of thinking, feeling, acting, although additional strengthening needed. Working to devise constructive future plans.

4. General awareness of relationship of environmental factors and stress but difficulty specifying for self. Able to recognize dysfunctional patterns but control and change is tenuous. (Example: Regular angry outbursts or depressive episodes.) Future plans vague.

5. Very limited or only rote awareness of relationship of environment to stress. (The "not me" type.) Still focuses on others' need to change ("I wouldn't have to behave this way, if they. . . .").

9. Concern About Becoming Ill

1. Shows appropriate concern about becoming ill. Appropriate affective response to effects on life, dangerousness, and self-image.

2. Appropriate concern about illness, but may be more emotionally detached. Fewer specific concerns about effects on life, but clearly motivated to avoid dangerousness.

3. Concerned about future illness but difficulty accepting the possibility of recurrence. Same for dangerousness. Motivation to avoid illness is good, although may not specify reason.

4. Minimizes possibility of recurrence of illness. Minimizes possibility of future dangerousness.

5. Believes recurrence of illness is impossible or exremely unlikely.

10. Plans for Reemergence of Illness

1. Family and friends are aware of symptoms and prepared to alert mental health personnel if necessary. Patient can be expected to establish good contact with Community Mental Health (CMH) personnel. Patient, family, and friends aware of emergency services. Patient trusts mental health personnel and knows importance of early intervention.

2. Limited independent support system (i.e., family and friends) but can be expected to make good contact with CMH personnel. Aware of emergency services. Knows importance of early intervention. Shows good trust of mental health personnel.

3. Can be expected to rely on at least one responsible friend or family member, and make good contact with at least one member of the CMH community. Knows importance of early intervention.

4. May have adequate support, as in (3), but prefers to make early attempts to control illness on own. Has good potential support system, but difficulty with trust prevents effective use of support system.

5. Limited support and poor contact with mental health professionals. Adequate support but very mistrustful. Strong belief that mental illness can be self-controlled ("Now I'll know that the voices aren't real").

11. Relationship of Illness to Crime

1. Can Identify personal dynamics that predispose to illness and commission of crime.

2. Difficulty identifying predisposing dynamics, although open to work in this area. Can describe affective states or dis-

tortions of reality produced by illness and understands how these distortions or states are linked to crime.

3. Can describe affective states or distortions of reality produced by illness and understands how these distortions or states are linked to crime. Resists idea of predisposing factors.

4. Knows that illness leads to loss of control but has difficulty identifying specific distortions or affective states.

5. Believes crime is independent of illness, although may acknowledge being ill at time of crime.

12. Acceptance of Responsibility for Crime

1. Able to provide clear description of crime with roles of relevant factors such as drugs, aspects of illness, etc. Documentation that patient has displayed appropriate emotional response to the material.

2. May not remember all details of crime but accepts responsibility. Able to relate relevant factors as above. Appropriate emotional response as above.

3. Reluctant to describe crime and other efforts to distance. When questioned will provide detail. Embarrassment and other attempts at emotional distancing.

4. Focuses on lack of importance of talking about crime ("I've told the story so many times"). Needs to share blame with family, environment, drug use. Minimizes impact of crime ("I'd feel sorry, but . . .).

5. Will not talk about crime or does so glibly without assigning importance. Blames others or environment and may show anger attached to blaming.

13. Need to Continue Treatment

1. Shows consistent interest and progress in therapy and is motivated to pursue treatment following release.

2. Attempts to use therapy may meet with only moderate success, but good cooperation and strong recognition of continued need for preventive supervision.

3. Prefers to view self as not needing support services, but when approached properly maintains investment in treatment. Has a good history of inhospital treatment participation.

4. Believes that illness is well-controlled and may only be willing to participate in medication review. Although may attend therapy, consistently resistant to therapeutic intervention, either passively or actively. If there is any meaningful participation, it only occurs with a specific therapist.

5. Looks on hospital experience as punishment and looking forward to "topping out." Willing to accept community treatment only as a rapid means of exiting from the hospital.

14. Future Plans

1. Has constructive and achievable goals for living, work, school, family. Has made initial steps in hospital toward achieving goals.

2. At least one clearly defined, well-conceived goal that will help organize patient's life. Steps toward goal started.

3. Goals sound realistic but steps toward goal vague or initiated only with difficulty.

4. Goals are vague or deferred, even though patient shows motivation to avoid past errors.

5. Impractical, unachievable, fantasy-based plans or goals that fail to acknowledge need to avoid past difficulties (e.g., "I think I can handle my mother now" even though no significant contact has occurred).

15. Accepts COT Restrictions

1. Understands rules and shows ability to creatively adjust life-style to rules.

2. May question rules and experience as limiting but willing to follow rules because will lead to achievement of long-term goals.

3. Finds rules to be limiting and shows occasional opposition. Generally willing to follow rules and responds well to guidance.

4. Although no outright rule breaking, persistent challenging of authority and stretching of limits.

5. Can not understand rules. Strong oppositional tendencies.

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