RISK FOR DISCIPLINARY INFRACTIONS AMONG INCARCERATED MALE YOUTHS

Influence of Psychiatric Disorder

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The authors examine the contribution of disorder to disciplinary infractions among incarcerated male youths. In all, 176 youths recently admitted to a secure assessment center self-administered the Voice Diagnostic Interview Schedule for Children–IV. Demographic and justice-related data were abstracted from official records. Younger boys, minority youths, and those who stayed longer were found to infract more. Controlling for these factors, infraction risk was significantly lowered by anxiety, affective disorder, disruptive behavior, or substance use disorder (vs. no disorder), as well as more or more types of disorder. Youths with mental health concerns were less likely to infract. Results highlight the importance of employing systematic and universal screening rather than relying on observable management problems to identify mental health needs.

Keywords: *juveniles; assessment; disciplinary infractions; Voice Diagnostic Interview Schedule for Children*

Juvenile justice agencies dedicate a considerable amount of financial and human resources to maintain institutional safety. Youths who commit disciplinary infractions while incarcerated pose management problems and constitute a threat to self and others. Most standards for management of youths in secure care include consideration of youth misconduct (e.g., American Correctional Association, 1991); current practices commonly include formal documentation of misconduct and application of graduated sanctions. Despite management concerns and existing procedures to discipline those who commit infractions, however, the contribution of mental health status to juveniles' risk for institutional misconduct is typically not addressed in practice.

Justice practitioners who work with adults have long been aware of both the management and mental health concerns associated with disciplinary infractions (Coe, 1961; Fox, 1958; Goetting & Howsen, 1986; Myers & Levy, 1978; Toch & Adams, 1986; Wooldredge, 1991; Wright, 1991). A meta-analysis of 39 studies of adult prisoners (Gendreau, Goggin, & Law, 1997) found that the strongest predictors of disciplinary infractions were offense history

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(e.g., substance-related or violent; number of priors), antisocial attitudes and psychopathic traits, and institutional factors, such as overcrowding. Although studies with incarcerated populations provide some empirical support for a relationship between adult antisocial behavior and institutional misconduct (Hare, Hart, & Harpur, 1991; Hare & McPherson, 1984; Hobson, Shine, & Roberts, 2000), the relationship between mental health status, particularly psychiatric disorder, and institutional misconduct has been less explored.

Juvenile offenders and their adult counterparts share several risk factors related to mental health that have been associated with institutional misconduct. Adjustment to confinement can evoke feelings of anxiety and anger in juveniles, as it can for adults (Boothby & Durham, 1999; Gibbs, 1987; Silverman & Vega, 1990); justice-involved youths who lack effective coping skills or who are aggressive or anxious are more prone to act out behaviorally (Davis, Bean, Schumacher, & Stringer, 1991; McShane & Williams, 1989). Similar to adults, youths with extensive and serious arrest histories (Cottle, Lee, & Heilbrun, 2001), those affiliated with gangs (Esbensen & Huizinga, 2005; Thornberry, Krohn, & Lizotte, 1993), those who have been victimized (Falshaw & Browne, 1997; Lake, 1993; Lauritsen, Sampson, & Laub, 1991), and those with recent substance use (Smith, Wish, & Jarjoura, 1989) are at increased risk for misconduct.

Among incarcerated juveniles, rates of psychiatric disorder have been found to be as high as 65% (Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Although externalizing disorders (e.g., conduct or substance abuse) are known to be common among youths in the juvenile justice system, there is an increasing awareness of elevated rates of internalizing disorders (e.g., anxiety or depression) as well (Teplin, Abram, McClelland, & Dulcan, 2002; Wasserman et al., 2002). Surprisingly, mental health diagnostic status, above and beyond the contribution of other factors, has received little attention as an independent contributor to disciplinary infractions among these youths.

Investigations of the contribution of adolescent mental health concerns to disciplinary infractions have not considered disorder per se, but some have focused on psychopathy or psychopathic traits. Some of those who have investigated psychopathy in incarcerated adolescents report associations with increased aggression and misconduct (Brandt, Kennedy, Patrick, & Curtin, 1997; Falshaw & Browne, 1997; Forth, Hart, & Hare, 1990), although others have failed to replicate these findings (e.g., Serin, 1991). There are limitations to the assessment and management of psychopathy in juveniles. Although instruments that measure psychopathy identify certain prominent features of Antisocial Personality Disorder (American Psychiatric Association, 1994) that may relate to misconduct, some have cautioned against applying to youths the psychopathy construct from adults (Edens, Skeem, Cruise, & Cauffman, 2000; Grisso, 1998) because, in recognition of their developmental fluidity, children and adolescents cannot obtain a diagnosis of Antisocial Personality Disorder. This means that it is important to extend the examination of associations between mental health concerns and institutional misconduct beyond consideration of psychopathy and into a study of Axis I disorders. In the same light, adolescent psychopathy has been negatively associated with internalizing or emotional problems (e.g., anxiety, depression; Brandt et al., 1997; Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999; Frick, O'Brien, Wootton, & McBurnett, 1994; Toupin, Mercier, Dery, Cote, & Hodgins, 1996). By inference, then, we might expect that adolescents with internalizing disorders would show lower levels of institutional misconduct. In other work, institutional misconduct has been found to relate to some, but not all, nondiagnostic symptom scales (Butler, Loney, & Kistner, 2007).

To better understand risks for juveniles' institutional misconduct, we examined the independent relationships between the nature and complexity of disorder and disciplinary infractions among male youths in a postadjudicatory secure facility.

METHOD

PARTICIPANTS

We secured the support of the director of the New Jersey Juvenile Justice Commission, who provided access to youths at the New Jersey Training School for Boys (NJTSB). NJTSB is a secure orientation and assessment center where male youths who have been committed to state custody are initially admitted, assessed, and later placed.

Participation was voluntary; participating youths signed assent. Incarcerated youths are in the custody of their state's juvenile justice commissioner, and there are well-documented practical difficulties in obtaining parental consent for these procedures (Ko, Wasserman, McReynolds, & Katz, 2004). Accordingly, after assessment, in lieu of active parental consent, legal caretakers of participating youths received a project information sheet describing the study and were offered an opportunity to withdraw their son's data.

During a 2-month data collection period, 217 boys were asked to participate; all but 7 agreed. In addition, seven assessments were not included for technical or logistical reasons (e.g., power outage). Five parents withdrew their son's data. One youth's data were excluded from analysis after systematic review detected implausible completion times coupled with inappropriate responses to open-ended questions. Diagnostic data were available, then, for 197 boys, reflecting a response rate higher than 90%. Data on infractions while in the facility were not available for 9 youths, and 12 youths were missing information on number of prior convictions; therefore, analyses were based on 176 youths with complete data.

PROCEDURES

Psychiatric assessment. The Voice Diagnostic Interview Schedule for Children–IV (V-DISC: Wasserman et al., 2002) was administered to participants an average of 23 days (range: 0-72 days) after their admission to the facility. Youths were selected depending on availability. Monitors read a script to solicit participation and took youths' assent; then, youths self-administered the V-DISC via computer by using headphones to listen to prerecorded questions (viewed simultaneously on a computer screen). By reducing the need for an interviewer, the V-DISC offers advantages for low-resource settings, such as those in juvenile justice, that want to screen for provisional diagnostic status (Wasserman, Jensen, Ko, Trupin, & Cocozza, 2003); the V-DISC is in wide use across a range of juvenile justice settings nationwide (see www.promotementalhealth.org for more information).

Follow-up procedure. Disciplinary infraction records were examined for the period from January 4, 2000 through January 18, 2001. For 60 participating youths who were still being assessed at this facility at the close of data collection, only infractions that occurred prior to or on January 18, 2001, were considered (see below). For an additional subset of juveniles (<5%, $n = 9$), whose ultimate placement was a residential facility on the same campus, available records did not include information on date of transfer from the assessment center

TABLE 1: Demographic, Offense, and Disorder Characteristics of Sample (*N* = 176)

Characteristics	*M* (*SD*)	*% (n) / Range*
Age (years)	17.3 (1.3)	12.7-22.0
Current academic grade	9.8 (1.3)	6th-10th grade
History of grade retention[a]		66.1 (111)
Preincarceration physical fighting[a]		72.4 (123)
Minority status		82.4 (145)
Number prior convictions	6.1 (4.1)	
Days between intake and assessment	22.7 (10.8)	
Days in residence	130.0 (87.1)	
Short (0-75 days)		35.8 (63)
Medium (76-225 days)		49.4 (87)
Long (226+ days)		14.8 (26)
Nature of current offense[b]		
Interpersonal		31.6 (55)
Non-Interpersonal		42.5 (74)
Other[c]		25.9 (45)
No disorder		38.1 (67)
Any anxiety disorder		16.5 (29)
Any affective disorder		9.7 (17)
Any disruptive behavior disorder		21.6 (38)
Any substance use disorder		47.7 (84)
Infractions while at NJTSB	1.4 (2.6)	0-15

a. Percentage based on slightly reduced *N* because of missing data.
b. *N* = 174 because of missing data for two youths.
c. Includes offenses such as violation of probation, status offense, court order to appear, and so forth.

to that facility. As a result, for those boys, the tally of infractions that occurred both before and after residential placement is considered herein.

MEASURES

Demographic and offense characteristics. Background information for each youth was abstracted from official records regarding age, ethnicity, current academic grade, number of prior convictions, and nature of current offense(s) and is presented in Table 1. Official dates of admission to and release from the NJTSB were used to compute youths' length of stay. Because youths who remained at the NJTSB for a longer period had a greater opportunity to infract, analyses controlled for number of days in custody. Because the distribution of length of stay was highly skewed, we created three categories: short (0-75 days), medium (76-225 days), and long (226+ days).

Current offenses were designated as interpersonal or noninterpersonal. Interpersonal offenses included aggravated or sexual assault, robbery, and all weapons charges; noninterpersonal offenses included all others (e.g., nonconfrontational property and substance-related offenses). Because we lacked data on originating offense for 39 youths incarcerated for probation violations, we coded current offense as "other." We coded youths whose committing offenses included both interpersonal and noninterpersonal activities as interpersonal offenders. As part of the V-DISC's introduction module, youths reported whether they had ever been held back in school (vs. never).

Psychiatric disorder. The DISC has been used in research investigating the prevalence of mental disorder among justice youths (Duclos et al., 1998; Garland et al., 2001; Randall, Henggeler, Pickrel, & Brondino, 1999; Teplin et al., 2002; Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005). Among justice youths, the V-DISC's validity has been demonstrated against externalizing disciplinary problems (Friman et al., 2000) and offense history (Wasserman et al., 2002). There are no significant differences in the 1-month reliability of diagnoses between self- and interviewer-administered versions; most kappas range between 0.5 and 0.7 (Lucas et al., 2002). Test-retest reliability is as good as, or better than, previous versions of the DISC (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). Prevalence rates, based on the V-DISC, observed in this sample are comparable with those reported in other samples of correctional youths (see Wasserman et al., 2002).

The V-DISC generates disorders present in the past month; consistent with the logic of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994), some diagnoses are based on symptoms that may have been present across a longer time frame (e.g., substance use disorder). Data were scored with Version E algorithms and analyzed with SPSS 15.0 (2007); 20 disorders were assessed via the V-DISC and, following earlier reports (Wasserman et al., 2002), were grouped into four diagnostic clusters and two psychiatric domains: *Disruptive behavior disorders* (DBDs) included attention-deficit hyperactivity, oppositional defiant, and conduct; *substance use disorders* (SUDs) included abuse/dependence of alcohol, marijuana, and other substances; *anxiety disorders* included agoraphobia, posttraumatic stress disorder, social phobia, specific phobia, generalized anxiety, panic, and obsessive–compulsive; and *affective disorders* included mania, hypomania, major depressive, and dysthymia. Youths meeting criteria for a DBD and/or SUD were coded as having an *externalizing* disorder (vs. no disorder); youths meeting criteria for an anxiety and/or affective disorder were coded as having an *internalizing* disorder (vs. no disorder).

Disciplinary infractions. State policy mandates that youths charged with an infraction are afforded due process (i.e., right to contest the charge, call witnesses) before the infraction is officially recorded. Only those disciplinary infractions for which youths were subsequently found guilty were considered in this study. Infractions ranged from minor (e.g., verbal disruption) to more serious events (e.g., stabbing). Although more than half the youths (58.5%) never infracted, nearly 20% had three or more infractions; because the number of infractions was highly skewed (i.e., most never infracted) and nonlinearly associated with disorder (see Results section), we created a dichotomized variable (any vs. none).

ANALYSIS

First we examined infraction rates for youths with and without each DISC diagnostic cluster. Next, logistic regression analyses considered the contribution of diagnostic characteristics to misbehavior, controlling for retained covariates. We used a backwards stepwise approach wherein all potential confounders (age, school grade, minority status, preincarceration physical fighting, grade retention, duration of stay, number of prior convictions, and whether current offenses were interpersonal) were initially placed in regression models, along with diagnostic variables (examined separately). Covariates were retained if they had a p value of less than .20 or if previous research indicated they were strongly associated with

institutional misconduct. Because history of physical fighting, living with a close relative, history of grade retention, and nature of current offense did not contribute to any model prediction, all four were removed from final models. In addition, school grade was removed from regression equations because it was highly correlated with age ($r = .62$, $p < .001$). Finally, because of nonlinearity, we used the natural logarithm of the length-of-stay variable in regression analyses.

A series of regression analyses assessed the contribution of each disorder cluster, over and above demographic and offense characteristics, in predicting disciplinary infractions. The base model (Model 1) considered the contribution of demographic and offense characteristics. The next four models (Models 2-5) separately considered the contribution of each type of diagnostic cluster, adjusting for the factors examined in Model 1. For example, in Model 2, we compared individuals with any anxiety disorder to nondisordered youths. In Model 3, we compared individuals with any affective disorder to nondisordered youths. Likewise, Models 4 and 5 compared individuals with any SUD and any DBD, respectively, to nondisordered youths. Finally, additional adjusted analyses examined the contribution of number of disorders and number of diagnostic clusters to disciplinary events.

RESULTS

SAMPLE CHARACTERISTICS

Table 1 presents sample characteristics for all participants. On average, youths were 17 years old and had not yet completed the ninth grade, placing them 2 years behind expected grade level. Most were African American or Hispanic. The average youth had 6.1 prior convictions, had been at the NJTSB for close to 3 weeks at time of assessment, and remained there for approximately 4 months. Most youths were currently incarcerated for interpersonal crimes and reported a history of physical fighting. Comorbidity was common: Almost 35% reported two or more disorders, and almost 30% reported disorders in two or more diagnostic clusters. More than 40% reported an externalizing disorder only, and fewer than 8% reported an internalizing disorder only. Approximately 15% of youths reported disorders in both domains.

COVARIATES, MENTAL HEALTH STATUS, AND DISCIPLINARY INFRACTIONS

Table 2 presents the unadjusted associations between disorder cluster and disciplinary infractions, as well as the odds ratios, adjusted for demographic and justice processing characteristics. Before adjustment, compared with youths with no disorder, only SUD was significantly (negatively) associated with infracting: boys with SUD were approximately one third less likely to infract. Next, considering only demographic and justice processing characteristics, younger boys, minority youths, and those who stayed at NJTSB longer were significantly more likely to infract. Expectably, length of stay had the strongest independent association with infracting, explaining approximately 30%-40% of the variance in each of the five models.[1] For example, without consideration of disorder characteristics, for each natural logarithm unit increase in length of stay, the odds of disciplinary infraction increased 11%-23% compared with youths with no disorder.

TABLE 2: Logistic Regression Odds Ratios (ORs) Predicting Disciplinary Infraction

	Model 1 Demographic & Offense Characteristics		*Model 2 Any Anxiety Disorder*		*Model 3 Any Affective Disorder*		*Model 4 Any Substance Use Disorder*		*Model 5 Any Disruptive Disorder*	
Predictor Variables	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*
Before adjustment										
Diagnostic cluster	—	—	0.68	0.44-1.04	0.59	0.34-1.05	0.69*	0.50-0.95	0.86	0.58-1.28
After adjustment										
Age	0.74	0.44-1.24	0.70	0.41-1.19	0.63	0.35-1.15	0.54**	0.36-0.81	0.57	0.32-1.01
Minority status	4.22	0.74-24.03	5.70	0.94-34.74	4.41	0.69-28.16	6.15**	1.72-22.07	6.73*	1.26-35.88
Number prior convictions	1.03	0.90-1.17	1.00	0.88-1.15	0.93	0.80-1.08	0.97	0.87-1.08	0.97	0.85-1.10
Length of stay[a]	13.57***	4.81-38.30	20.46***	5.84-71.71	16.23***	4.73-55.62	12.07***	5.21-27.96	22.56***	6.59-77.25
Anxiety disorder[b]	—	—	0.40**	0.20-0.80	—	—	—	—	—	—
Affective disorder[c]	—	—	—	—	0.33*	0.14-0.79	—	—	—	—
Disruptive disorder[d]	—	—	—	—	—	—	0.54*	0.32-0.89	—	—
Substance use disorder[e]	—	—	—	—	—	—	—	—	0.46*	0.23-0.92
ΣR^2	58.6		64.7		64.9		60.7		67.6	

Note. Empty cells indicate variables not included in regression models.
a. Natural logarithm of days between intake and DISC assessment.
b. $n = 93$.
c. $n = 79$.
d. $n = 100$.
e. $n = 146$.
*$p < .05$. **$p < .01$. ***$p < .001$.

Adjusted models presented in Table 2 explain a considerable proportion of outcome variance in odds of infracting (56%-68%); youths in all four cluster categories were less likely to infract. Youths reporting an internalizing disorder were 60%-67% less likely to infract (Model 2 for Anxiety Disorder, OR = .40, $p < .01$; Model 3 for Affective Disorder, OR = .33, $p < .05$) compared with nondisordered youths. Those reporting an externalizing disorder were 50% less likely to infract. Compared to nondisordered youths, boys with SUD were 54% less likely to infract (Model 4 for SUD, OR = .54, $p < .05$). Even boys with DBD were less likely to infract (Model 5 for DBD, OR = .46, $p < .05$) than were nondisordered youths. The protective effect of disorder was slightly stronger for internalizing disorders (ORs of .40 and .33) compared with that for externalizing disorders (ORs of .54 and .46). Beyond demographic and offense characteristics, diagnostic variables contributed an additional 2%-9% of the variance in disciplinary infraction.

CONSIDERATION OF COMORBIDITY

Most youths reported comorbid disorders: Only 14 (14.3%) of the 98 youths reporting an anxiety disorder failed to report a disorder in another cluster; only 1 (1.2%) of 83 affectively disordered boys did not report a disorder in another cluster; 45 (28.9%) of 156 substance-disordered boys did not report a disorder in another cluster; and only 9 (8.6%) of 105 boys with DBD did not report a disorder in another cluster. Youths reporting either more disorders (OR = .70, $p < .05$) or more diagnostic clusters (OR = .62, $p < .05$) were significantly less likely to infract compared with those with less complex mental health profiles.[2] With each increase in the number of disorders or number of diagnostic clusters, the odds of infracting decreased by 30% and 38%, respectively.

DISCUSSION

Consistent with prior research, younger boys, minority youths, and those who stayed in custody longer were more likely to infract during a 4-month period. Controlling for these factors, however we characterized disorder (e.g., number of disorders or clusters, particular types of disorder), youths with mental health concerns were significantly less likely to infract while in custody. Internalizing disorders were slightly more protective than were externalizing disorders.

Our findings are partially consistent with those observed in adult inmates. Toch and Adams (1986) found that prisoners with conduct problems or antisocial personality disorders had high violation rates, whereas those with substance or anxiety disorders had lower rates of disciplinary infractions. Toch and Adams compared individuals with a particular disorder to those without that disorder, whether or not they also had some other disorder. In contrast, our comparisons are between those with a particular disorder and those without any disorder, with the same reference group for all comparisons. Using different comparison groups for different analyses increases error and makes detecting a true effect more difficult. As noted earlier, most boys in this and in other juvenile justice samples present with complex comorbid mental health profiles. For example, of the 38 boys reporting a DBD, 29 also reported an SUD, 5 also reported an anxiety disorder, and 4 also reported an affective disorder. Presence of any of these comorbid disorder types reduced the likelihood that a boy would infract. Almost three fourths (71%, $n = 5$) of the 7 youths who endorsed a DBD,

but no other type of disorder, infracted, whereas far fewer (39%, $n = 12$) of the 31 youths with a DBD plus some other type of disorder infracted. As highlighted below, these results underscore the need for comprehensive mental health screening and assessment. Agencies that automatically assign a DBD diagnosis to incoming incarcerated youths without delving further into mental health concerns will likely fail to provide needed services, but they may also expect and plan for management and disciplinary problems that may be, in fact, relatively unlikely to occur.

These results are not consistent with a recent report linking Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2) subscale scores to disciplinary infractions (Butler et al., 2007) among incarcerated male youths. In that investigation, the sole behavioral domain to positively predict infractions was the Angry–Irritable subscale. Neither subscales measuring internalizing behaviors (Depressed–Anxious) nor those measuring alcohol or drug use were related to institutional misbehavior. In hit rate analyses, 59% of infracting youths were correctly classified based on MAYSI-2 cutoff scores. Most predictive errors resulted from false negatives on the Angry–Irritable subscale (that is, youths below the subscale cutoff who nonetheless infracted). There are two substantial differences between this study and the report of Butler et al. (2007). First, consistent with a host of earlier studies, our report considers the role of mental health after adjustment for demographic and offense characteristics that also influence infracting; Butler et al. did not adjust for other youth features. In our results, demographic and justice processing characteristics made far stronger contributions to infracting than did disorder. Second, this article examines diagnostic features, whereas the MAYSI-2 Angry–Irritable subscale used in the Butler et al. study has no diagnostic counterpart (Wasserman et al., 2004). Irritability is a common symptom that occurs in many disorders. These differences suggest that the behavioral specificity offered by diagnosis improves the ability to predict who will (and who will not) infract.

Mental health status and infractions. We found that internalizing disorders were slightly more protective than were externalizing disorders in predicting infraction risk, but overall, youths with mental health concerns were less likely to infract, likely reflecting their high degree of comorbidity. These results underscore the recent interest in universal mental health screening and assessment for youths in juvenile justice settings (Skowyra & Cocozza, 2006). If only those youths with obvious management problems during incarceration are identified and referred for mental health assessment, agencies will miss most youths' mental health concerns. This finding, along with the high degree of co-occurring internalizing disorders among this sample of incarcerated youths, substantiates practice guidelines that recommend comprehensive and reliable mental health assessment among youths in justice settings (Weiss, Jackson, & Susser, 1997). Lopez-Williams and colleagues (Lopez-Williams, Vander Stoep, Kuo, & Stewart, 2006) argued that in the absence of systematic screening for mental health need, justice gatekeepers make use of "proxy variables" (such as disciplinary events) to determine which youths need services.

LIMITATIONS AND RESEARCH RECOMMENDATIONS

This study population consists of youths from a single secure facility for boys, so results may not be representative of youths located in other facilities or in other states or of girls

in secure care. Replication studies with other justice populations that include girls should be conducted. Nevertheless, although the sample was not large enough to yield sufficient power to analyze individual disorders, the general pattern of responses was consistent with the literature indicating that internalizing disorders can inhibit externalizing behavior (e.g., Gray, 1987), which provides confidence that the findings are unlikely to be site specific.

A second limitation to this study was lack of access to treatment information. Adult prisoners receiving substance abuse treatment (Innes, 1997) are as much as 74% less likely to engage in misconduct than are those who do not receive treatment. Langan and Pelissier (2001) attribute this finding to the impact of changes during the treatment process on inmates' cognitive and emotional state that, in turn, influence their behavior. Although DISC results did not systematically contribute to clinical decision making, those who had been identified with a disorder by the DISC may have received some type of mental health treatment which, in turn, may have reduced their likelihood of infracting.

Finally, disciplinary infractions considered here represent officially reported misbehavior. Many antisocial acts committed in custody remain unreported, so our measure of disciplinary infractions likely underestimates the true level of institutional misbehavior. Agency records have been found to underestimate risk of violence when compared with more comprehensive indices that include official, informal, and self-report (Steadman et al., 1998). Although institutions may be most concerned about individuals who engage in severe misbehavior, we did not have information available regarding the seriousness of disciplinary infractions. A more fine-grained examination of the characteristics of disciplinary events would allow for interesting differential comparisons across disorder types.

NOTES

1. We examined how the timing of the V-DISC might affect findings by dichotomizing the variable reflecting the number of days between intake and assessment at the median (≤20 days vs. 21+ days), and rerunning regression Models 2-5. Results were equivocal: there was no difference in the contribution of either DBD or SUD to infractions, whether or not youths were assessed immediately on intake. Anxious youths who were assessed longer after intake were less likely to infract than were those assessed shortly after intake (ORs = .23 and .59).

2. Data available from corresponding author.

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