to define true co-morbidity, look at some related sub-definitions, and examine the consequences this has on the treatment options and outcome of anxiety disorders.

Recent epidemiological data demonstrate a clear connection between the anxiety and mood disorders and also a link from depression to dementia.

New biological and epidemiological evidence of anxiety disorders points to a potential for preventative psychiatry with the anxiety disorders. These data and theories will be presented.

THE END OF RISK ASSESSMENT AND THE BEGINNING OF START

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Actuarial risk assessment scales have not quite fulfilled the expectation that objective rating schemes would assist in identifying individuals at high risk of acting violently. Such scales tend to sample a relatively small number of risk factors, and often exclude other, often rarely occurring, factors that may be as important in particular individuals. Actuarial scales also do not assess how risk factors interact, or for how long they are valid. None takes into account the possible influences of protective factors. There is a new generation of instruments, represented by the Short-Term Assessment of Risk and Treatability Scale (START), developed in Vancouver, which attempts to address these shortcomings and to provide an individualised approach to assessing risk.

PSYCHIATRIC DISORDERS AND PSYCHOSOCIAL CORRELATES OF HIGH HIV RISK SEXUAL BEHAVIOUR IN WAR-AFFECTED EASTERN UGANDA

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BACKGROUND: Studies from developed countries have shown psychiatric disorders to be a risk factor for HIV infection, with one of the suggested pathways being through increased risky sexual behaviour.1 There are few data on this association from sub-Saharan Africa and an absence of programming to address this risk factor in HIV prevention on the continent.

OBJECTIVES: To investigate the psychiatric and psychosocial risk factors for high-risk sexual behaviour in a vulnerable population in war-affected Eastern Uganda.

METHODOLOGY: A cross-sectional survey was carried out in 4 sub-counties in two districts in Eastern Uganda. 1 560 randomly selected respondents (15 years and above) were interviewed. The primary outcome was a derived variable 'high-risk sexual behaviour' defined as reporting at least one of 13 sexual practices that have been associated with HIV transmission in Uganda. Multivariable logistic regression was used to assess factors associated with high-risk sexual behaviour in this population.

RESULTS: Males were more likely to have at least one 'high-risk sexual behaviour' than females (14.0% v. 11.6% in the past year). Sex outside marriage was the most common 'high-risk sexual behaviour', reported by 12% of married participants in the past year. Factors independently associated with 'high-risk sexual behaviour' among males were being a victim of intimate partner violence (OR 3.34, 95% CI 1.97 - 5.66), having a major depressive disorder (OR 1.93, 95% CI 1.19 - 3.12), and being in the middle tertile poverty index (OR 2.12, 95% CI 1.11 - 4.03 compared with the lowest tertile). Among females these factors were previous exposure to war-related sexual violence (OR 1.96, 95% CI 1.17 - 3.28), previous exposure to war-related physical trauma (OR 1.73, 95% CI 1.05 - 2.87), and having a gynaecological problem (OR 2.49, 95% CI 1.53 - 4.05).

CONCLUSION: In both genders, psychiatric and psychosocial risk factors were significantly associated with high-risk sexual behaviour, although directions of causation cannot be inferred from this cross-sectional study.

RECOMMENDATIONS: HIV/AIDS prevention programmes in conflict and post-conflict settings should address the psychiatric and psychosocial wellbeing of these communities.

1. Collins P, Holman AR, Freeman MC, Patel V. What is the relevance of mental health to HIV/AIDS care and treatment programs in developing countries ? A systemic review. *AIDS* 2005;20:1571-1582.

ONE YEAR OF FORENSIC PSYCHIATRIC ASSESSMENT IN THE NORTHERN CAPE: A COMPARISON WITH AN ESTABLISHED ASSESSMENT SERVICE IN THE EASTERN CAPE

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INTRODUCTION: Occupying the largest land mass of South Africa's nine provinces, the Northern Cape is also the least populated, with 1.1 million people. In 1994 the N Cape became a separate province. This development necessitated the establishment of an autonomous health department, including the treatment of state patients and assessment of accused persons referred for psychiatric observation by courts. A forensic psychiatric service tasked with the assessment of accused persons was established in 2008.

METHODS: This study is retrospective and descriptive in design. The period of study extends from 2008 to July 2010. As data on all cases over this period are available, no cases were excluded. Data contained on the *forenSys* database were used. The descriptive parameters on the accused referred for psychiatric assessment and selected for inclusion in the study were as follows: biographical – age, gender, marital status, financial support, highest level of education; legal – index offence; clinical – Axis I, II and III diagnoses; assessment findings: ability to follow proceedings (able or unable), criminal capacity (responsible, diminished responsibility and not responsible).

Similar data from the forensic service at Fort England Hospital, Grahamstown, E Cape, comprising 1 000 cases assessed during the period September 2004 - July 2010 were obtained and statistically compared with the Northern Cape data using a chi-squared approach. Eastern Cape data were obtained from the Fort England *forenSys* database.

The selected data parameters were obtained by means of an SQL-query in Microsoft Access. Statistical analysis was performed using Statistica software at the Department of Statistics, Rhodes University, Grahamstown. Consistency in descriptive approach and diagnosis was strengthened because one of the authors (CV) had been involved in both the Eastern and Northern Cape assessments.