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Evaluating the department of health recruitment strategy: an international perspective

Nitin Gupta

*Margaret Stanhope Centre,
South Staffordshire and Shropshire Healthcare NHS Foundation Trust,
Burton upon Trent, UK*

Vinesh Gupta

St Andrew's Healthcare, Northampton, UK, and

Gurpreet Singh

*St George's Hospital,
South Staffordshire and Shropshire Healthcare NHS Foundation Trust,
Stafford, UK*

Abstract

Purpose – The purpose of this paper is to assess the experiences of internationally recruited (IR) consultant psychiatrists focussing on the recruitment process and its adherence to the department of health (DH) guidance.

Design/methodology/approach – IR consultant psychiatrists ($n = 88$) from different countries were mailed a 13-item questionnaire assessing their experiences regarding various aspects of the recruitment process.

Findings – In total, 48 per cent IR psychiatrists responded; 97 per cent were from India. The recruitment process was generally satisfactory with perceived gaps in support from various stakeholders. Inconsistent experiences were reported regarding induction, mentorship, clinical responsibilities, and racial discrimination.

Originality/value – This is believed to be the first such questionnaire-based study carried out on the IR consultant psychiatrists and discussing their experiences of the overall recruitment process.

Keywords Recruitment, Consultants, Psychiatry, Doctors, Globalization, National Health Service

Paper type Research paper



The authors would like to acknowledge the support and help provided by Workforce Capacity – DH, Leeds in their attempt to recruit potential candidates (consultant psychiatrists recruited from countries other than India) for the study. They also would like to place on record their gratitude towards their IR colleagues who participated in and facilitated various aspects of this study, especially the seven IR consultants who participated in the pilot component of the study related to questionnaire development.

This paper is based on the study entitled “Experiences of the internationally recruited consultant psychiatrists: a questionnaire study” which had the approval of South Staffordshire Local Research Ethics Committee and the Research and Innovation Group of South Staffordshire Healthcare NHS Foundation Trust. Declaration of interest: Nitin Gupta and Gurpreet Singh were recruited as consultant psychiatrists in December 2003 through the Global Recruitment Scheme of the DH.

Introduction

The department of health (DH) launched a global recruitment campaign in September 2001, specifically to identify doctors interested in working in England either as consultants or GPs. The campaign targeted shortage specialties, and specialties where significant expansion was needed to meet the targets identified in the NHS plan. Additionally, the International Fellowship Programme was launched in January 2002 and was intended to attract experienced specialists from abroad to selected posts in the NHS for periods of one to two years (DH, 2002a).

Since 2002, more than 100 psychiatrists have been recruited from different countries (predominantly from India) and appointed as consultants in the NHS (Goldberg, 2004). There has been considerable discussion in the recent past on International Recruitment of Psychiatrists with sharing of experiences by some of the Internationally Recruited (IR) psychiatrists (Chaturvedi, 2006a; George *et al.*, 2006; Gupta and Gupta, 2006; Mellor, 2003; Patel, 2003; Shah *et al.*, 2006). A previous paper discussed various issues regarding the IR psychiatrists and the recruitment process (Gupta and Gupta, 2006) but was not data-based. Deodhar (2006) had also commented on the need for a survey to gather data from these IR psychiatrists. Hence, this study was planned using a questionnaire based-approach. The aims were to assess the overall experiences of these IR consultant psychiatrists during the recruitment process, thereby evaluating whether this recruitment process was in accordance with the guidance provided in the DH (2002a) document. We additionally attempted to understand as to how some of these experiences fulfilled the guidance provided within the framework of clinical governance (DH, 1999, 2002b).

Material and methods

Sample

The sample comprised IR consultant psychiatrists working in the NHS. They were broadly categorised into two groups for logistic purposes (as explained below) – those recruited from India, and those recruited from other countries by the DH.

Two streams of contact were used:

- (1) Consultants recruited from India were approached using the database available with the principal researcher (Nitin Gupta (NG)). NG is the Secretary of Internationally Recruited Indian Doctors Association – UK (IRIDA-UK) and moderator of the IRIDA-UK e-group. The membership of IRIDA-UK comprises of Indian doctors who have joined as NHS Consultants in various specialties through the DH Recruitment Schemes (Gupta and Gupta, 2006). It is however important to note that not all IR consultants from India are part of IRIDA-UK.
- (2) Consultants from other countries were primarily approached with the support of the International Recruitment Workforce – DH.

Instrument

Based on areas highlighted in a previous paper (Gupta and Gupta, 2006) and outlined in the DH (2002a) document, supplemented with personal experiences and communication with other IR Indian consultants, a 13-item questionnaire was constructed. The questionnaire was then piloted on seven IR consultants and their

feedback was incorporated into the final version of the questionnaire. The questionnaire took about 15-20 minutes (on average) for completion.

It had two sections:

- (1) *Section A*: "Demographic profile."
- (2) *Section B*: "Recruitment process" that comprised of items with different patterns of responses (either yes/no; actual figures, etc.), and also had an open ended section for "any other comments" after each question.

This was available for participants to put in any other relevant information.

Section B addressed various aspects of procedures involved during the process of recruitment (specialist training authority (STA) equivalence, General Medical Council (GMC)), relocation, and also the processes put in place for these IR psychiatrists by their employing trusts, The Royal College of Psychiatrists (RCPsych) and other relevant agencies involved in the process. The questionnaire additionally focussed on the clinical-related and system processes (related to supervision and mentoring) made available to these doctors.

Procedure

The participant group was identified as previously described under sample. A total of 88 potential participants (excluding two of the authors) were identified through the combined sources (out of these 77 were from India). The initial administration of the questionnaire as part of the study was carried out in April-May 2006. The questionnaire was sent to each individual by post and/or e-mail; to be returned to the investigators within four weeks. A reminder was then sent to all participants two weeks after the initial contact.

Responses from the returned questionnaires were listed, which included collation of the "comments" provided by the participants. Regarding the potential use of comments for this paper, the respondents were further divided into three categories:

- (1) those that provided consent;
- (2) those that did not provide consent; and
- (3) those who desired to look at their comments before providing consent.

Those who fell in category (3) were sent their individual comments for final consent. Only those comments were considered for use from the category (3) respondents who provided final consent.

Statistical analysis

Data available were analysed by frequency tabulation of individual items of the questionnaire. An attempt was also made to determine if any appropriate or comparable sub-groups could be generated for meaningful comparison. Additionally, the comments (for different parts of the questionnaire) were incorporated, wherever deemed appropriate, as part of the discussion below.

Under the section of "relocation", the available results showed a wide range of satisfaction by respondents. Hence, to generate a more meaningful understanding, the results were divided on the principle of one-thirds leading to the emergence of three broad strands, i.e. "reasonably adequate support (upper 1/3rd)", "just adequate support (middle 1/3rd)", and "inadequate support (lower 1/3rd)".

Ethical considerations

Involvement in this study was voluntary. The participant had the freedom to withdraw consent at any time during the course of the study without providing any reason. Confirmation was provided that a decision to withdraw would not affect the professional relationships. It was also ensured that there were no identified risks or disadvantages. The identity of all the participants was kept anonymous and the data were collected in accordance with the Data Protection Act (Controller of HMSO, 1998). The study had the approval of South Staffordshire Local Research Ethics Committee and the Research and Innovation Group of South Staffordshire Healthcare NHS Foundation Trust.

Results

Some of the results across different categories are presented in Table I, whereas the others are presented as below:

- (1) *Response rate*: of the 88 questionnaires that were sent out, 42 people returned them complete with their responses; a response rate of 47.72 per cent.
- (2) *Background data*: there were 40 (95 per cent) male and 2 (5 per cent) female respondents. About 41 of the respondents were from India (IRIDA-UK) and one from Germany. Predominantly the respondents were working in general adult psychiatry (38, 90 per cent), with two (5 per cent) in old age psychiatry, one (2.5 per cent) in child psychiatry, and one (2.5 per cent) in substance misuse. Seven (17 per cent) of the respondents were recruited through the global recruitment scheme, 33 (78 per cent) through the International Fellowship Scheme and two (5 per cent) were recruited through other sources.
- (3) *Specialist training authority (STA) equivalence*: the process was rated as satisfactory by 40 (95 per cent) respondents. In terms of time taken for the process, 27 (64 per cent) reported that the process took less than six months (seven reported that the process was completed in less than three months) while 14 (33 per cent) mentioned that the process took more than six months (six reported a duration of greater than nine months). One respondent (3 per cent) did not provide any response.

Parameter	Score-average values	Score-range obtained
<i>Background data</i>		
Duration in psychiatry (years)	14.08	6-26
Duration of working as consultant before joining NHS (years)	7.45	0-21
<i>Induction programme</i>		
Duration of induction (days)	15.1	0-180
Duration of shadowing (days)	15.8	0-90
Duration of mentorship/clinical supervision (days)	113.4	0-730
<i>Clinical/on-call responsibilities</i>		
Taking on actual clinical responsibilities after date of commencement (days)	22	0-90
Placed on "on-call rota" after date of commencement (days)	80	0-240

Table I.
Results related to the ordinal data obtained from the questionnaire

- (4) *GMC registration*: 32 (76 per cent) of the respondents found the process simple while 10 (24 per cent) found it complex.
- (5) *Decision to join NHS*: the reasons, in decreasing order of frequency, provided were – financial (30 responses; 71 per cent), professional satisfaction (29 responses; 69 per cent), membership of the RCPsych (20 responses; 48 per cent), dissatisfaction with Indian health services (11 responses; 26 per cent), and other miscellaneous reasons (19 responses; 45 per cent). As more than one reason was provided by many of the respondents, hence the total number (and percentage) was greater than 42 (100 per cent).
- (6) *Relocation – help from DH regarding visa application*: 34 (81 per cent) respondents found the help provided by the DH satisfactory during the process of visa application.
- (7) *Help from relocation agency*: relocation was primarily handled by a specific agency, and this was assessed under various areas (Table II).
- (8) *Induction programme*: seven (17 per cent) reported receiving no induction. Additionally 13 (31 per cent) reported receiving no shadowing.
- (9) *Supervision/mentorship*: 17 (41 per cent) reported receiving none (with three indeterminate responses). Regarding specific areas, 22 (52 per cent), 22 (52 per cent), 17 (41 per cent), and 18 (43 per cent) respondents reported receiving mentorship in clinical, managerial, systems related, and multi-agency working, respectively.
- (10) *Clinical/on-call responsibilities*: this was analysed under various headings:
 - Training of Mental Health Act (MHA)-1983: only 14 (33 per cent) received MHA training prior to accepting clinical responsibilities and 29 (69 per cent) received it prior to carrying out on-call responsibilities.
 - After receiving MHA training, 36 (86 per cent) reported that the training was relevant to their clinical responsibilities and 32 (76 per cent) reported that the training was relevant to their level of understanding of the MHA.

Table II.
Categorization of
responses related to “help
from relocation agency”

Area	Response as “adequate” (per cent)	Response as “inadequate” (per cent)	Responses not considered for analysis (per cent)
Travel to and from work	12 (29)	26 (61)	4 (10)
Information regarding driving license	9 (21)	30 (72)	3 (7)
National insurance number	8 (19)	31 (74)	3 (7)
Inland revenue	7 (16)	31 (74)	4 (10)
Pension	6 (14)	31 (74)	5 (12)
Bank account	30 (72)	10 (24)	2 (4)
Housing (rent/mortgage)	30 (72)	7 (16)	5 (12)
Housing (location/convenience)	29 (69)	9(21)	4 (10)
GP registration	18 (43)	21 (50)	3 (7)
Child care and education	13 (31)	20 (48)	9 (21)
Job opportunity for spouse	3 (7)	31 (74)	8 (19)

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- (11) *Relevant support and guidance from the RCPsych*: 21 (50 per cent), eight (19 per cent), eight (19 per cent), and seven (17 per cent) respondents reported receiving relevant support and guidance from The RCPsych for CPD, appraisal and revalidation, supervision and line management roles, and membership, respectively. However, four (10 per cent) provided no response regarding membership.
 - (12) *Adequate support and guidance from the trust*: 19/35 (54 per cent), 27/42 (64 per cent), and 14/25 (56 per cent) respondents reported receiving adequate support and guidance from their Trust for research opportunities, clinical governance and audit, and teaching and supervision, respectively. However, 7 (17 per cent) and 17 (41 per cent) of the sample provided no response regarding research and teaching, respectively.
 - (13) *Racial discrimination*: 6 (14 per cent), 14 (33 per cent), 1 (3 per cent), and 3 (7 per cent) respondents reported experiencing racial discrimination (as defined by www.cre.gov.uk/legal/discrimination.html) in social life, by patients, by trust management, and by colleagues, respectively.

Owing to small numbers, we were unable to generate any comparable sub-groups (for parameters of – type of recruitment, gender, date of joining the NHS, etc.) for meaningful comparison. Hence, the discussion is based on the whole sample, rather than any sub-groups.

Discussion

The consultant recruitment through the Global Recruitment Scheme and the International Fellowship Scheme by the DH has no precedence anywhere in the world and there is no literature evaluating the success or failure of this initiative. Several discussions have taken place looking at the ethical considerations of International Recruitment, but none to address the experiences of these professionals. Our study is an attempt to understand these experiences in order to inform any such future initiatives. However, the results obtained should be interpreted in light of certain basic facts underpinning the process of International Recruitment of Consultant Psychiatrists by the DH. This process involved various stakeholders, i.e. RCPsych, GMC, STA, NHS trusts, and the DH itself. Nevertheless, it needs to be borne in mind that international recruitment of healthcare professionals is a well established practice (DH, 2004).

A response rate of 48 per cent places a higher degree of confidence on the results being reflective of the perceptions and experiences of the study group. The male preponderance is in line with the profile of the study group. All but one respondent (97 per cent) were from India. This generated a homogeneous group with similar issues and similar training background, thereby making the results more applicable and generalisable to the IR Indian Psychiatrists only. These consultants had considerable experience and expertise and all were on the Specialist Register of the GMC. This aspect is quite heartening as it confirms that the recruitment process adhered to one of the essential basic principle (point 4 under Guiding Principles, p. 8) of International Recruitment (DH, 2004). Most of the respondents are working in General Adult Psychiatry, an understandable fact due to lack of training in other psychiatric sub-specialities in India (Das *et al.*, 2002; Gupta and Gupta, 2006).

The process of STA equivalence and GMC registration was reported as satisfactory and simple by an overwhelming number of respondents, which reflected a good coordination between the relevant professional bodies (RCPsych, STA, GMC). This is again in keeping with the Code of Practice principles (DH, 2004) and indicative of good recruitment practice.

Financial issues and professional satisfaction were the commonest reported reasons for joining NHS, and maybe reflective of the perceived financial and professional dissatisfaction in India, and/or the search for better incentives in the UK by the respondents. Another reason mentioned by many was related to the "Membership of RCPsych", a subject of considerable debate in recent months (Bhugra, 2006; Chaturvedi, 2006b).

Relocation

Relocation has been acknowledged as a complex and stressful experience (DH, 2002a; Gupta and Gupta, 2006). For all practical purposes, the relocation process was managed by Phoenix ARC (the relocation company contracted by the DH for IR). The relocation company was contracted by the DH (2003) to "provide an enhanced service" and support the recruitment process and the doctors. As our study only addressed the experiences and perceptions of the IR psychiatrists, it may be difficult to make a definitive statement that the relocation company was not able to adhere to the standards of service for which they were contracted. Nevertheless, perceived inadequate support by respondents in various areas key to the relocation process does raise concerns as lack of adequate and appropriate support not only undervalues, but can be detrimental to, the overall recruitment process.

Induction, mentorship, and clinical responsibilities

The DH guidance recommended that all IR consultants should ideally have a three-month induction period; stressed the importance of recognising that these fully trained doctors might have different needs in comparison to the young newly trained doctors; and that the induction should cover three areas, i.e. "general induction", "induction into clinical practice" and "not directly clinical but relevant medical induction" (DH, 2002a, 2003) and this responsibility lay with the employer and the workforce development confederation. In our study, we did not address the specifics of individual agreement between the respondents and their employing trusts/medical directors regarding their period of induction. Cumulative responses reflected extremely limited induction (mean of 15.1 days) and shadowing (mean of 15.8 days). But, probably most concerning was a significant minority of respondents reporting complete absence of induction and shadowing, and taking on clinical responsibilities in approximately three weeks raising issues around "safe and effective clinical practice". Active clinical responsibilities were taken on within an average of three weeks (up to a maximum of three months) of joining, with two reporting clinical work from the first day itself. Also, 69 per cent reported not having received training in relation to the MHA of 1983. Although they were placed on the on-call rota approximately three months (with some starting on day one only) after commencement of job, nearly 33 per cent reported no training of the MHA prior to carrying out on-call responsibilities. It has been mentioned that clinical risk management and interpretation-cum-implementation of the MHA is not an easy task even for a

UK-trained consultant (Gupta and Gupta, 2006; Kapur *et al.*, 2005). Brown and Humphries (2003) discussed the requirement for MHA training to make doctors “fit for purpose” and to be placed in the context of clinical governance, recognizing the “special needs” of overseas doctors employed at senior levels. In our opinion, this aspect is of concern as the trusts may have been overly enthusiastic in entrusting clinical (including on-call) work on the NHS-naïve overseas consultants. From the viewpoint of GMC standards for clinical governance and safe practice, such entrusting of clinical responsibilities (of a NHS consultant) may be termed too premature and potentially risky. This is an aspect that trusts should be mindful of, and highlights inadequate pastoral support to the respondents, with discontinuity of agreement on the recruitment principles between the DH (2003) and the trusts. As the predominant respondents found the MHA training to be relevant to their clinical responsibilities and level of understanding of the MHA, they may have felt more supported if the MHA training had been provided at an appropriate time after joining. One method suggested expediting approval and employment is through the local medical director in order to ensure at least provisional approval under the MHA (Brown and Humphries, 2003). It is acknowledged that this process may have been followed with some IR consultants, though we are not aware of it.

The RCPsych has long recognised the stress associated with the appointment to first consultant job for specialist registrars with issues around complexities of responsibilities, requests and demands of their leaderships and professional skills, the necessity of managing their working practice in relation to the needs of colleagues, managers and other professionals (Dean, 2002; Naeem *et al.*, 2005) with the first year as a consultant being particularly difficult (Holloway *et al.*, 2000). The RCPsych has also advised that a newly appointed consultant should have access to a senior colleague – a Mentor for advice, support or information during the most difficult, early years in post (Holloway *et al.*, 2000; Roberts *et al.*, 2002). These issues would logically and understandably be more relevant to the IR consultants who are new to the country with very limited information about the system (Gupta and Gupta, 2006). Mentorship/clinical supervision was provided, on average, for approximately four months with majority receiving reasonably comprehensive mentorship. But, probably the most concerning aspect emerging out of this study was that 41 per cent respondents did not receive any mentorship or supervision. These findings should be interpreted in the context of the duration and importance of mentoring period (up to six months) and process highlighted elsewhere (DH, 2003). Also, it is pertinent to mention that mentoring has been conceptualized as a long-term (spread over years) process (Roberts *et al.*, 2002). We, however, did not formally examine the impact of mentoring in our group of IR consultant psychiatrists.

A comprehensive review (Holloway *et al.*, 2000) discussed the high degree and multiplicity of stress associated with the job of a consultant psychiatrist. They further emphasize the need of adequate training for undertaking these roles, highlighting the central issue of CPD with relevant support from the trusts. However, only 54-64 per cent reported receiving adequate support and guidance on these aspects from their trust and these figures, combined with the discussion above on “mentoring and support”, suggests lack of:

- uniformity of applying these measures by the employing trusts; and
- appropriate links and communication between the DH and the employing trusts.

This raises issues in relation to adhering to the principles of clinical governance, and should be borne in mind by stakeholders during future recruitment drives, as developing appropriate support systems is a multi-agency responsibility (Holloway *et al.*, 2000).

Apart from CPD, inadequate support was perceived from The RCPsych. The important role of the RCPsych has been highlighted in providing advice and support to the IR consultants (George *et al.*, 2006). Though there is mention of proposal of mentorship by The RCPsych, yet we were unable to find detailed information on their web site in relation to ongoing guidance and support for even “home-grown” newly appointed consultant psychiatrists (Dean, 2002; Roberts *et al.*, 2002). Egerton *et al.* (2005) also discuss the need for mentorship on these issues. In our opinion, this would be an area which could benefit from detailed, in-depth development and implementation of a plan by The RCPsych to support “newly appointed consultant psychiatrists” in the future.

A significant percentage of respondents experienced racial discrimination. It is again difficult to comment whether the racial discrimination was actual, perceived, or both. However, this highlights a probable failure of the systems during the recruitment process by the DH, and does raise concerns in general for obvious reasons that do not require further elucidation. Also, we are not in a position to comment whether the DH (and its recruitment team) were made aware about “racial discrimination” by the affected respondents.

Recommendations

Greater attention is required towards the overall concept and framework of clinical governance so as to ensure delivery of high-quality standards of care in the NHS. It is important that any such future initiatives take into account the need for appropriate supervision and mentorship, training of the relevant MHA, a sufficient period of induction including exposure to the relevant systems and procedures in place. It is also important that all measures should be put in place to ensure good quality service with a view to minimise risk for patients as well as staff.

Limitations

Certain limitations of this study also need to be kept in mind. Firstly, all (except one) respondents were from India which considerably limits generalisability. Secondly, this study only addressed psychiatrists and not professionals from other specialities. It is highly possible that the experiences of other professionals will be different due to their unique professional needs. Thirdly, the design of the study did not permit us to evaluate experiences of other stakeholders involved in the recruitment process (i.e. DH, RCPsych, GMC, etc.). It would be extremely interesting if such data were available, and there may be a possibility that these may have been studied though we are not aware about any such official publications/press releases. Fourthly, the recruitment process so evaluated was specifically focussed at a consultant level and may not be applicable in entirety to other forms (or levels) of recruitment. Lastly, a response bias may be expected, i.e. only those people responded who had “not too positive” experiences. But, this appears unlikely as many aspects were reported as being positive.

To conclude, the DH (and its various partners) appears to have achieved reasonable success with the process of recruitment of consultant psychiatrists within the broad

framework of clinical governance. There are however areas for improvement which should be taken into consideration for any possible future recruitment. This study, despite its limitations, does indicate that a complex recruitment process can be a successful venture provided one adheres to the basic ethical principles and code of conduct.

References

- Bhugra, D. (2006), "College response to ... Through the back door: the college and award of membership without examination", *Psychiatric Bulletin*, Vol. 30, p. 6.
- Brown, N. and Humphries, M. (2003), "Training for approval under section 12(2) of the Mental Health Act 1983", *Advances in Psychiatric Treatment*, Vol. 9, pp. 38-44.
- Chaturvedi, S.K. (2006a), "The International Fellowship Scheme: from Silicon Valley to Potteries and back", *Psychiatric Bulletin*, Vol. 30, pp. 226-7.
- Chaturvedi, S.K. (2006b), "What's in an MRCPsych!", *Psychiatric Bulletin*, Vol. 30, p. 354.
- Controller of HMSO (1998), "Data Protection Act", *Queen's Printer of Acts of Parliament*, HMSO, London.
- Das, M.K., Gupta, N. and Dutta, K. (2002), "Psychiatric training in India", *Psychiatric Bulletin*, Vol. 26, pp. 70-2.
- Dean, A. (2002), *The Role of a Mentor for Newly-appointed Consultants*, Royal College of Psychiatrists, London, available at: www.rcpsych.ac.uk/traindev/tutors/mentorsAug02.pdf
- Deodhar, J. (2006), "Recruitment from India", *Psychiatric Bulletin*, Vol. 30, p. 234.
- DH (1999), *Clinical Governance: Quality in the New NHS*, Department of Health, London.
- DH (2002a), *International Recruitment of Consultants and General Practitioners for the NHS in England: Current Initiatives and Guidance to NHS Employers on an Infrastructure to Support International Recruitment*, Department of Health, London.
- DH (2002b), *Standards for Better Health*, Department of Health, London.
- DH (2003), *International Recruitment Global Scheme: Recruitment Process*, Department of Health, London.
- DH (2004), *Code of Practice for the International Recruitment of Healthcare Professionals*, Department of Health, London.
- Egerton, J., Swann, A. and Foley, B. (2005), "Shadowing consultant psychiatrists: the need for change", *Psychiatric Bulletin*, Vol. 29, pp. 182-5.
- George, S., Calthrope, B. and Khandelwal, S.K. (2006), "The International Fellowship Scheme for consultant psychiatrists: trainees' perspective", *Psychiatric Bulletin*, Vol. 30, pp. 229-31.
- Goldberg, D. (2004), "The NHS International Fellowship Scheme in psychiatry", *Psychiatric Bulletin*, Vol. 28, pp. 433-4.
- Gupta, V. and Gupta, N. (2006), "Internationally recruited Indian psychiatrists in the NHS: are we achieving the best-fit model?", *Psychiatric Bulletin*, Vol. 30, pp. 81-4.
- Holloway, F., Szmulker, G. and Carson, J. (2000), "Support systems. 1. Introduction", *Advances in Psychiatric Treatment*, Vol. 6, pp. 226-35.
- Kapur, N., Cooper, J. and Rodway, C. *et al.* (2005), "Predicting the risk of repetition after self-harm: cohort study", *BMJ*, Vol. 330, pp. 394-5.
- Mellor, D. (2003), "Commentary: recruitment is ethical", *BMJ*, Vol. 327, p. 928.
- Naeem, A., Rutherford, J. and Kenn, C. (2005), "From specialist registrar to consultant: permission to land", *Psychiatric Bulletin*, Vol. 29, pp. 348-51.

- Patel, V. (2003), "Recruiting doctors from poor countries: the great brain robbery?", *BMJ*, Vol. 327, pp. 926-8.
- Roberts, G., Moore, B. and Coles, C. (2002), "Mentoring for newly appointed consultant psychiatrists", *Psychiatric Bulletin*, Vol. 26, pp. 106-9.
- Shah, M., Goswami, S., Singh, G. and Brown, R. (2006), "Overseas consultant psychiatrists moving into the NHS: initial experience", *Psychiatric Bulletin*, Vol. 30, pp. 228-9.

About the authors

Nitin Gupta is a General Adult Psychiatrist in South Staffordshire and Shropshire Healthcare NHS Foundation Trust. His research and clinical interests are liaison psychiatry, seasonal affective disorder, early and acute psychosis, and clinical psychopharmacology. He also has a keen interest in trans-cultural psychiatry and evidence-based medicine. He has, till date, more than 100 research publications. Nitin Gupta is the corresponding author and can be contacted at: nitingupta659@yahoo.co.in

Vinesh Gupta, MRCPsych, PGCME is a Consultant Adolescent Forensic Psychiatrist at St Andrew's Healthcare. His main areas of interest are recruitment and retention, teaching and training and emerging personality disorder in adolescents.

Gurpreet Singh completed his Doctor of Medicine in Psychiatry from Government Medical College, Amritsar (India) and further completed his senior residency in psychiatry from All India Institute of Medical Sciences, New Delhi (India). He worked as an Assistant Professor and Head of the Department in RPGMC & Hospital in Dharamsala (India) for two years before relocating to England. He is currently working as a General Adult Psychiatrist in South Staffordshire and Shropshire Healthcare NHS Foundation Trust for last four years. He relocated to England through Global Recruitment Scheme of the DH in December 2003. His main research and clinical interests are community psychiatry, mood disorders and clinical psychopharmacology. His other area of interest is dual diagnosis and has a keen interest in teaching and training. He has presentations at both local and international level.