Regular Article

Child and adolescent psychiatry in the Far East

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Aim: Despite the general consensus on the importance of youth mental health, the scarcity of child and adolescent mental health services is prominent all over the world. Child and adolescent psychiatry (CAP) postgraduate training can play a pivotal role in increasing access to youth mental health services. In comparison to Europe and North America, however, little is reported regarding CAP training in the Far East, one of the most dynamic and rapidly developing world regions with a very young population. This paper presents an original study on the current status of academic child and adolescent psychiatry training across the Far East.

Methods: We collected data from 17 countries in the Far East using an internally distributed questionnaire to the Consortium members invited for this study, consisting of leading academic child and adolescent psychiatrists in each country.

Results: Based on informants’ input, we found an overall underdevelopment of CAP postgraduate training systems despite CAP’s recognition as a subspecialty in 12 of 17 of the nations or functionally self-governing areas in the Far East. Paucity of official guidelines for CAP training was also evident. All informants reported a need for additional child and adolescent mental health professionals.

Conclusion: There seems to be several obstacles to the development of CAP postgraduate training in the Far East, including stigma towards mental health issues and lack of funding. International collaboration is desired to develop evidence-based and culture-tailored CAP training systems.

Key words: child and adolescent psychiatry, education, mental health service, postgraduate training, the Far East.

Mental health is an essential part of children’s and adolescents’ health. It interacts complexly with general physical health and significantly impacts upon ability to succeed in school and society. According to the World Health Organization (WHO), approximately 10–20% of youth experience mental health disorders.

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health disorders (The World Health Report 2001. http://www.who.int/whr/2001/en/whr01_en.pdf?ua =1). Furthermore, 70% of mental health disorders have their onset prior to the age of 25 years.1 Untreated mental health problems in childhood can be transmitted into various psychiatric diseases.2 Moreover, there are several psychiatric disorders (i.e. early-onset neurodevelopmental disorders) that are most often diagnosed in childhood and that require early interventions.

Accordingly, there has been an increased need for child mental health services in both developing and developed countries. However, there is a tremendous amount of unmet need. According to the WHO Child and Adolescent Mental Health Atlas, the vast majority of countries (with the exception of some countries in Europe and the Americas) do not have adequate youth mental health services (http://www.who.int/mental_health/publications/atlas_child_ado/en). Furthermore, a study conducted by Morris et al. reflected an overall scarcity of child mental health services and a mental health gap in which low- and middle-income countries lag significantly behind high-income countries.3 This study also reported a higher rate of unmet needs in child mental health training in low–middle-income countries. The WHO Atlas also reported that general psychiatrists, pediatricians and general practitioners often care for youngsters with mental illness in these countries. Other mental health professionals, including psychiatric nurses, psychologists and social workers – even without the benefit of having had specific training – may also play important roles in child and adolescent mental health services.

Although child and adolescent psychiatry (CAP) is a recognized specialty in much of North America and Europe, and although postgraduate CAP training is distinct, systematized, and generally intended to produce a workforce to meet health-care needs, there is often an uneven distribution of specialists and a subsequent shortage in rural areas.4 In Europe, one survey found variability in terms of quantity and quality of CAP training among the different countries,5 and in the USA, Sexon et al. reported several CAP training challenges, including recruitment, funding, and insuring competence for trainees.6

In an article focused on West and South Asian countries, Srinath reported that, in comparison to Europe and North America, there have been huge unmet needs for CAP resources in Asia, notwithstanding the rapidly growing numbers of youngsters who require mental health evaluation and ongoing care.7

At this point, there is relatively little published about CAP needs and about CAP training and academic CAP in the Far East region. The Far East includes countries and functionally self-governing areas in East and Southeast Asia (see Table 1). This is one of the most dynamic and rapidly developing world regions, with a very young population (United Nations Statistical Yearbook for Asia and the Pacific 2011, http://www.unescap.org/stat/data/syb2011/I-People/1.6-Children-and-the-elderly.pdf).

Within the past 2 decades, several articles have reported emerging needs related to the paucity of child and adolescent mental health resources in several Far East countries.8–11 More recently published articles on CAP training in Hong Kong, Malaysia, Singapore,12 and Japan13 reported severe workforce shortages in child and mental health services.

In order to investigate CAP needs and map and optimize training programs for future workforce development in this region, the Consortium on Academic Child and Adolescent Psychiatry in the Far East (CACAP FE) was established in 2011. This Consortium was supported by the World Psychiatry Association, Section on Child and Adolescent Psychiatry, Group on Teaching and Learning. Accordingly, in this paper, we report the results of information gathered through this Consortium and discuss potential future implications for CAP training in the Far East region.

**METHODS**

**Subjects/survey**

For the purposes of this project involving descriptions of medical educational systems that likely would be influenced by area-specific populational and economic factors, we defined the Far East region as including the following 20 countries and functionally self-governing or specially administered areas: Brunei, Cambodia, People’s Republic of China (China), East Timor, Hong Kong (technically a Special Administrative Region of the People’s Republic of China), Indonesia, Japan, Lao People’s Democratic Republic (Lao PDR), Macau (technically a Special Administrative Region of the People’s
Republic of China), Malaysia, Myanmar, Mongolia, North Korea, Philippines, Russian Far East Region (Russia), Singapore, South Korea, Chinese Taipei (also known as Taiwan, though not a recognized distinct country by the UN), Thailand, and Vietnam.

Leading academic child and adolescent psychiatrists in the Far East were invited to join CACAP FE. There were no objections or refusals expressed in participating in the CACAP FE. So, CACAP FE included official representatives of CAP in identified countries and areas, all of whom were affiliated with academic universities, research facilities or specialty societies. Via an internally distributed questionnaire (administered over a period of 10 weeks), the Consortium members provided information on current CAP postgraduate training and education systems. Information was organized into an EXCEL spreadsheet, the accuracy of which was checked by three authors (T.H., A.G., and N.S.).

<table>
<thead>
<tr>
<th><strong>Country</strong></th>
<th>No. of qualified psychiatrists</th>
<th>No. of psychiatrists treating youth</th>
<th>National guideline for psychiatry training</th>
<th>Duration of training (months)</th>
<th>CAP recognized as subspecialty (years)</th>
<th>CAP exposure during general training</th>
<th>CAP postgraduate training</th>
<th>National guideline for CAP training</th>
<th>Duration of CAP training (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brunei</strong></td>
<td>4</td>
<td>1</td>
<td>NR</td>
<td>NR</td>
<td>Y (2005–)</td>
<td>NR</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>Cambodia</strong></td>
<td>41</td>
<td>N</td>
<td>Y</td>
<td>36</td>
<td>Y (1996–)</td>
<td>NR</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>China</strong></td>
<td>20,500</td>
<td>500</td>
<td>Y</td>
<td>36</td>
<td>Y (1980–)</td>
<td>Y (2 months)</td>
<td>Y</td>
<td>N</td>
<td>36</td>
</tr>
<tr>
<td><strong>Hong Kong</strong></td>
<td>300</td>
<td>30</td>
<td>N</td>
<td>&gt;72</td>
<td>Y</td>
<td>Y (6 months)</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>Indonesia</strong></td>
<td>600</td>
<td>40</td>
<td>N</td>
<td>24</td>
<td>Y (1978–)</td>
<td>Y (6 months)</td>
<td>Y</td>
<td>N</td>
<td>12</td>
</tr>
<tr>
<td><strong>Japan</strong></td>
<td>13,534</td>
<td>Most</td>
<td>Y</td>
<td>60</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>&gt;36</td>
</tr>
<tr>
<td><strong>Lao PDR</strong></td>
<td>2</td>
<td>2</td>
<td>N</td>
<td>NR</td>
<td>N</td>
<td>NR</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>Malaysia</strong></td>
<td>289</td>
<td>&gt;25</td>
<td>Y</td>
<td>18 or 36</td>
<td>Y</td>
<td>Y (4 months)</td>
<td>Y</td>
<td>Y</td>
<td>18 or 36</td>
</tr>
<tr>
<td><strong>Myanmar</strong></td>
<td>80</td>
<td>80</td>
<td>Y</td>
<td>24</td>
<td>N</td>
<td>Y (2 months)</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>Mongolia</strong></td>
<td>135</td>
<td>2</td>
<td>Y</td>
<td>12</td>
<td>Y (1978–)</td>
<td>Y (2 months)</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
<tr>
<td><strong>Philippines</strong></td>
<td>400</td>
<td>20</td>
<td>Y</td>
<td>36–48</td>
<td>Y (1972–)</td>
<td>Y (3 months)</td>
<td>Y</td>
<td>Y</td>
<td>24</td>
</tr>
<tr>
<td><strong>Russia</strong></td>
<td>509</td>
<td>72</td>
<td>Y</td>
<td>12–24</td>
<td>N</td>
<td>Y (4 months)</td>
<td>Y</td>
<td>N</td>
<td>1–4</td>
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<tr>
<td><strong>Singapore</strong></td>
<td>150</td>
<td>25</td>
<td>Y</td>
<td>36</td>
<td>N</td>
<td>Y (6 months)</td>
<td>Y</td>
<td>N</td>
<td>12</td>
</tr>
<tr>
<td><strong>South Korea</strong></td>
<td>2,000</td>
<td>400</td>
<td>N</td>
<td>48</td>
<td>Y (1980–)</td>
<td>Y (2 months)</td>
<td>Y</td>
<td>N</td>
<td>24</td>
</tr>
<tr>
<td><strong>Taiwan</strong></td>
<td>400</td>
<td>400</td>
<td>N</td>
<td>48</td>
<td>Y (1998–)</td>
<td>Y (3 months)</td>
<td>Y</td>
<td>Y</td>
<td>12</td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td>320</td>
<td>120</td>
<td>Y</td>
<td>36</td>
<td>Y</td>
<td>Y (3 months)</td>
<td>Y</td>
<td>Y</td>
<td>48</td>
</tr>
<tr>
<td><strong>Vietnam</strong></td>
<td>700</td>
<td>10</td>
<td>N</td>
<td>&gt;24</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>–</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Country</strong></th>
<th>Estimated no. of CAP electives overseas</th>
<th>Need for more CAP specialists</th>
<th>No. of CAP departments</th>
<th>CAP society</th>
<th>CAP scientific national journal</th>
<th>National CAMH policy</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
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<td><strong>Brunei</strong></td>
<td>N</td>
<td>Y</td>
<td>&gt;2</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>High</td>
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<tr>
<td><strong>Cambodia</strong></td>
<td>N</td>
<td>Y</td>
<td>5–10</td>
<td>0</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>China</strong></td>
<td>AU, UK, USA</td>
<td>Y</td>
<td>8000</td>
<td>15</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Hong Kong</strong></td>
<td>AU, UK</td>
<td>Y</td>
<td>20–30</td>
<td>2</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Indonesia</strong></td>
<td>AU, UK</td>
<td>Y</td>
<td>7000</td>
<td>0</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Japan</strong></td>
<td>UK, USA</td>
<td>Y</td>
<td>NR</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Lao PDR</strong></td>
<td>N</td>
<td>Y</td>
<td>51</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Malaysia</strong></td>
<td>AU, UK, USA</td>
<td>Y</td>
<td>??</td>
<td>0</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Myanmar</strong></td>
<td>N</td>
<td>Y</td>
<td>NR</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Mongolia</strong></td>
<td>South Korea</td>
<td>NR</td>
<td>NR</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Philippines</strong></td>
<td>AU, UK</td>
<td>Y</td>
<td>50</td>
<td>1</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Russia</strong></td>
<td>AU, UK, USA</td>
<td>Y</td>
<td>26</td>
<td>0</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Singapore</strong></td>
<td>AU, UK, USA</td>
<td>Y</td>
<td>NR</td>
<td>2</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>South Korea</strong></td>
<td>UK, USA</td>
<td>Y</td>
<td>200</td>
<td>30</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Taiwan</strong></td>
<td>UK, USA</td>
<td>Y</td>
<td>200</td>
<td>10</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td>UK, Singapore</td>
<td>Y</td>
<td>100</td>
<td>0</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td><strong>Vietnam</strong></td>
<td>N</td>
<td>Y</td>
<td>100</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

1Based on data from the World Bank.

2The data of Taiwan are not separated from that of China, but it is considered to be a high-income country as per the World Bank website.

AU, Australia; CAMH, child and adolescent mental health; CAP, child and adolescent psychiatry; Lao PDR, Lao People's Democratic Public; N, no; NR, not reported; Y, yes.
Questionnaire

The initial questionnaire was created by a CACAP FE board and piloted with input from five countries in the Far East. The questionnaire was composed in English. Following initial revisions, the final questionnaire included these questions:

1. How many qualified (board-certified) general psychiatrists are there?
2. How many of the general psychiatrists treat child and adolescent populations?
3. Is there a national guideline for postgraduate general psychiatry training?
4. What is the duration of general psychiatry training?
5. Is there any CAP exposure during general psychiatry training? If so, how long?
6. Is child and adolescent psychiatry recognized as a separate specialty (subspecialty)?
7. Is there a specialized postgraduate training program in CAP? If so, how long?
8. Is there a national guideline for postgraduate CAP training?
9. Are overseas CAP electives available for trainees? If so, in which countries?
10. Is there a need for more child and adolescent psychiatrists (and/or child adolescent mental health specialists)?
11. If so, what are the estimated numbers of required child and adolescent mental health professionals?
12. How many CAP departments affiliated to universities are there?
13. Is there a CAP society?
14. Is there a national CAP journal?
15. Is there a national child and adolescent mental health policy?

In this survey, we did not expand our questionnaires to the contents of CAP training, with an assumption that limited numbers of included countries and areas had structured training systems.

Ethics

Ethical approval was not required, as we engaged in organizing generally publically available information known to the consortium members, who were contributors on this report.

RESULTS

Information was provided from consortium members, who represented 17 out of 20 identified countries and areas in the Far East (East Timor, North Korea, and Macau were not represented). Information is summarized in Table 1. At the time of the study, the number of qualified psychiatrists ranged from two in Lao PDR to 21 500 in China. Similarly, the number of psychiatrists treating youth also varied from one in Brunei to most of the qualified psychiatrists (numbering 13 534) in Japan. National guidelines for general psychiatry residency training existed in 11 out of 17 countries and areas. The duration of this training varied from 12 months in Mongolia and Russia to 72 months in Hong Kong (median was 36 months). In 16 countries and areas, a mandatory exam was required to graduate from the training program. CAP rotations were available for trainees during general psychiatry residency in 12 out of 17 countries and areas (median was 3 months, and the range was 2–6 months). Some trainees were able to experience CAP electives in foreign countries, such as Australia, Canada, the UK, and the USA.

CAP was not recognized as a subspecialty in five countries (Japan, Lao PDR, Myanmar, Russia, and Singapore). CAP postgraduate training was available in 10 countries and areas, whereas national guidelines for CAP training existed only in four countries and areas. Among 10 countries and areas that provided data, the duration of CAP training varied from 12 to 48 months (median: 30 months). When countries were classified by income level based on data from the World Bank (http://data.worldbank.org), of note, CAP was recognized as a subspecialty only in 50% (3/6) of high-income countries and areas, whereas it was recognized as a subspecialty in all (9/9) middle-income countries. Furthermore, national guidelines for CAP postgraduate training existed only in Chinese Taipei (Taiwan) out of four high-income places in comparison to three middle-income countries (Malaysia, Philippines, and Thailand).

Shortage of CAP specialists was apparent, despite local needs, from the data of all countries and areas except for Mongolia (data not reported). Sixteen countries and areas estimated minimal numbers of required CAP specialists, which varied from two in Brunei to 8000 in China. In eight of the 17 included countries and areas, a national child and adolescent mental health policy was available. With regards to academic CAP, our results were not particularly

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DISCUSSION

To our knowledge this is the first survey to recognize and map current child and adolescent mental health services and CAP training system in the Far East region. It revealed overall underdevelopment of postgraduate CAP training systems and a resultant scarcity of services despite the awareness of unmet need and CAP's recognition as a subspecialty in 12 of 17 countries and areas.

Our results showed that national guidelines did not exist in six of 10 countries and areas in which CAP postgraduate training was available. On the other hand, Hägglöf found, in 2006, that national guidelines were available for CAP training in 16 of 19 European countries in which CAP postgraduate training was established (European Union of Medical Specialists. http://www.uemscap.eu/training). Furthermore, there were limited numbers of national CAP societies; national scientific journals specialized in psychiatry and/or CAP. These results imply inconsistent and fragmented training systems within individual countries and areas. Funding is likely a contributing factor to these results and thus is a pivotal issue for the commencement or improvement of CAP training in the Far East region. Of note, with diminishing state funds and funds from the National Institute of Mental Health, funding is also a challenging issue in North America where CAP training is well established.14 As the Far East region as a whole is experiencing unprecedented economic and population growth, there is an urgent need to prioritize funding for child and adolescent mental health services.

This study has also revealed that recognition of CAP as a subspecialty and existence of systematized training did not necessarily depend on income levels of the included countries and areas. For example, CAP remained unrecognized as a subspecialty, and there were no national guidelines for CAP training in some of the high-income countries, such as Japan and Singapore, despite the fact that literature from a few decades ago uncovered severe shortages of youth mental health services.8 This stagnation of child and adolescent mental health services development and training may be attributable to stigma towards mental illness in these countries and areas. It is reported that stigma delays help-seeking and thus prevents early detection and intervention, both of which are considered to play important roles in child and adolescent mental health even in the countries with long-standing CAP traditions.15 For example, the National Stigma Study–Children in the USA suggested that stigma can be a contributor to the delay of early intervention and treatment for children with mental health disorders.16 Governmental support and state leadership are also important, given that funding is one of the biggest obstacles for the development of CAP training systems, and that nationwide efforts are required to achieve success with challenging initiatives.17 Therefore, there is an urgent need to inform policy-makers about the current unmet needs for child and adolescent mental health services and to continue to persuade them to prioritize youth mental health among other issues. We hope that studies such as ours might help to start such a process in the immediate future.

It is encouraging that some countries and areas in the Far East can afford to send trainees to other countries mostly Australia, the UK, and the USA – where CAP training is systematized. Although training systems in these countries and areas may not always be applicable for the initiation of CAP training systems in the Far East region given cultural differences and the potential unavailability of evidence-based, modern treatments and diagnostic methods, sharing knowledge and skills between countries can be a good start to planning services in this region. In the face of limited availability of overseas experiences, video-conferencing technology can also facilitate international collaboration in CAP training, as has been done between the University of Indonesia and the University of Hawai’i.18

A need for additional CAP specialists is obvious in all countries and areas (ranging from an estimated two in Brunei to 8000 in China). Recruitment will be an inevitable issue to address in developing CAP training in the Far East region, given the persistent shortage of child and adolescent psychiatrists. Alternatively, allied professionals (general practitioners, advanced practice nurses and others) could be trained to address basic mental health needs of children and families. In China, for example, national guidelines have been issued to train primary care physicians to provide...
mental health services in children and adolescents (http://www.nhfpc.gov.cn/zhuozhan/wsmbgz/201304/23623f839ce64d0498e3d372115e6ce8.shtml. Available in Chinese). Such an approach has proven to be successful in some countries in South America.19

Our results showed that general psychiatry residents experienced CAP rotations during their postgraduate training in 12 of 17 countries and areas. Although we are not aware of any articles describing the benefit for CAP recruitment from CAP rotations during general psychiatry training, some articles report that early exposure to CAP didactics and clerkships for medical students increased their positive attitudes toward and resultant interest in this field.20,21

The main limitation of this study is its reliance on information-gathering within the assembled group of representatives: while there is potential strength in the formation of a Consortium, there may also be a lack of uniformity and reliability in how the questions are answered. It is also possible that current trainees’ experiences may be somewhat discrepant from the data reported by senior academic child and adolescent psychiatrists in our survey. Given that our survey included countries and areas in which paucity of CAP training systems and subsequent lack of key informants were evident, however, it might be appropriate to use one key informant for obtaining data. More importantly, most of our contributors informally consulted their colleagues and/or even government representatives prior to answering our questions.

It is important to emphasize that there are large heterogeneities – in culture, religion, and economics, among other things – across the countries and areas in the Far East. Therefore, rather than attempting to integrate CAP training systems across the Far East countries and areas, training systems may ideally be tailored to the unique culture of the country or area.

Despite these limitations, the strengths of our research are that this is the first survey on the CAP postgraduate training system in the Far East region and that it reflects fairly comprehensive information on under-developed systems in this region. The Far East has a long way to reach their expectations for child and adolescent mental health services and CAP training. In this new era, however, this stagnation must be changed. The Far East countries need to move forward for the sake of children and adolescents who should receive the best possible psychiatric care in order to lead productive lives. CACAP FE is committed to synergizing and optimizing CAP training across the Far East region by facilitating international collaboration in CAP training and research in order to provide each country and area with evidence-based and culture-tailored information.

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