Supplementary Table 1

MINI Kid Arabic specific challenges and recommendations, by section

Section, version & item		Challenges	Recommendations
A – MDD			
V6.0	V7.0.2		
A3 a,b,d	A3 a,b,d	During Ramadan, all fasting children reported symptoms of hunger, sleep difficulties and tiredness. In addition, these symptoms were common amongst children who worked and were undernourished.	Recommend taking fasting into account when making a decision about MDD and to re-assess when the child is not fasting. Recommend taking child labor and nutrition into account when assessing depressive symptoms.
Past 2 weeks and/or past episode		Many parents and children struggled to define the last 2 weeks. Often said yes to both past and current.	Recommend using a time marking for both short and long time spans, such as the school week, when fathers return from Beirut at the end of the week, since Eid, before starting the school year, or before leaving Syria. We found that this mostly works, but it can still be difficult to conceptualize when symptoms started.
B – Suicidality			
V6.0	V7.0.2		
B3,4,5	B3	It was common to refer to and express wanting to be dead to communicate being tired or fed up, that was unrelated to suicidal ideation.	Recommend that answers to suicidality questions should be explored in terms of meaning, asking for examples, to differentiate between metaphors and actual risk.
B1a,8,9,10	B1a	Questions were often seen to be repetitive and it was challenging to explain the conceptual differences between questions (the difference between *plan /* خطة and *intend /* نية, and the meaning of *intending to have an accident /* الفعل تنفيذ على نية.	In all questions, we recommend asking more questions when needed and being attentive to other non-verbal signs in order to explore further.

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NA	NA	The suicidality screening has no safety planning, script, or recommendations included to act on the presenting risk, including in terms of when/how to share risks with parents.	We recommend **adding a script and safety procedure to use when there is moderate to high risk**. We also recommend providing comprehensive training in risk management and the limits of confidentiality.
D – Mania			
V6.0	V7.0.2		
Family history question		We found it very hard to pin down whether a family member has had bipolar in the past, even with the prompts provided.	In order to assess this, assessors need clinical knowledge about bipolar affective disorder in order to be able to describe and explain.
D1a	C1a	Often parents and children understand the question – they say 'yes' but need to explain more. They think assessors are asking about happiness within normal range.	We recommend asking 1) when and 2) why. If reasons are related to for example Eid, a wedding, or other joyful events, then we can ask 'did you feel this at other times when alone?' This gives a sense of whether the experience is a sign of mania or joy within normal range. We also found it important to assess manic symptoms in the context of other disorders such as conduct disorder or ADHD.
E – Panic disorder			
V6.0	V7.0.2		
E4J	D4L	The question includes the word 'crazy' 'majnoon مجنون' which carries stigma, and assessors were too uncomfortable to use it.	We recommend **using the alternative phrase in Arabic of 'fakadet aaklak'/** فقدت عقلك meaning 'lost your mind,' a phrasing that carries much less stigma.
F – Agoraphobia			
V6.0	V7.0.2		
F1	E1	Parents and children often immediately say yes to the screening question, but when asked for more detail they describe normal experiences, such as being scared of seeing vans when they have heard of kidnappings.	Recommend asking for examples and trying to establish if the fears are generalized, such as fear in crowds even at a positive event like a wedding.

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NA	E6	Questions about the impact of the fear(s) at home or school, and the level of distress it causes, were vital in differentiating problematic symptoms from normal experience.	We recommend exploring these questions and using a complimentary severity scale, such as the Clinic Global Impression (CGI) scores to help inform diagnosis, formulation, and treatment.
NA	NA	We observed that many cases that met criteria for agoraphobia had no panic disorder symptoms. Whilst this may be valid we considered the possibility that the wording of panic disorder questions as highly somatic may have sounded like a physical problem.	Where there seemed to be hesitation about panic symptoms, they were explained further, to ensure that participants understood and could relate to their experience.
G – Separation anxiety disorder			
V6.0	V7.0.2		
G1	F1	As with F1/E1 parents and children often immediately say yes to the screening question, but when asked for more detail they describe normal experiences, such as missing their mum while she is in hospital.	
G1	F1	In addition, many children screened positively but named their best friend or sibling as the person they are afraid to be away from, rather than an parent or adult caregiver.	Due to the context of socio-economic disadvantage, many children spent more time with siblings and friends than with parents, and relied on them for their safety and wellbeing. We therefore accepted this under the DSM-V definition of 'major attachment figure.' In other cases, there was another causal reason, such as the terminal illness of a sibling.
G2b	F2b	Most children worried about something bad happening and this was entirely appropriate given the high risks of harm and injury, and was particularly prevalent amongst children who already have a parent who was missing or who died.	Children's worries were normal and adaptive in the context they were in, and we recommend being mindful to not pathologize these reactions, and to ensure they are taken into consideration only as part of an overall picture of separation anxiety.

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H – Social Anxiety Disorder (social phobia)			
V6.0	V7.0.2		
H1	G1	The screening questions were problematic because Syrian children regularly face social exclusion, bullying, and teacher's corporal punishment. Most children were therefore anxious about school and speaking in front of others (especially in front of Lebanese children).	Questions about the context of the situation, exposure to bullying, level of functional impairment and distress compared to others in same context (question H2/G4), are vital to differentiate between social anxiety *in context* and social anxiety *disorder.*
I – Specific phobia			
V6.0	V7.0.2		
I1	H1	Almost all children described significant fears of snakes, dogs, cats, helicopters, daesh and related cues, and fires. All these fears were related to frightening experiences; large snakes in tents at night, aggressive street cats and dogs, Lebanese army violence, past exposure to daesh violence, and fires in informal settlements, one of which killed a child in 2019.	As with H1/G1 we recommend asking questions about the context of the fear, and the level of functional impairment and distress *compared to others in same context* (question I3/H5), in order to differentiate between contextualized adaptive fear and a phobia.
J – Obsessive compulsive disorder			
V6.0	V7.0.2		
J1,4	I1	Parents and children found the screening questions very difficult to understand and they had to be explained extensively, using simpler and less complicated language.	Assessors need to be able to explain and give examples of OCD to help families understand, and we recommend training assessors in these common clinical disorders to help them explain.

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J6	I4	Children frequently met criteria for OCD based on excessive worry about something bad happening, and praying a lot or replacing worry thoughts with wishing their family well. This often met criteria except that the distress was associated with the content of the worry, rather than the intrusive symptoms themselves.	We recommend **follow-up questions to explore the content of reported obsessions or compulsions, and what triggers distress**. We recommend that the diagnosis only be assigned if distress is clearly associated with the intrusive symptoms of OCD, rather than underlying worry about safety which may be either normal within the context, or better explained by PTSD or GAD. We also recommend **omitting time as a way to distinguish clinical severity**, as praying under normal circumstances can take more than an hour a day. In the circumstances facing these families, we observed that praying was more frequent and has a protective function in coping and maintaining hope.
K – Post-traumatic stress disorder			
V6.0	V7.0.2		
K1	J1	Identifying traumatic events and distinguishing from stressful events was often challenging, with children sometimes declining to name the traumatic event (but otherwise meeting criteria) or saying 'no' to the occurrence of traumatic events, but describing traumatic events in response to other questions (often children who were being physically abused did not volunteer this as a traumatic event in the screening question). Some children would screen 'yes' to a traumatic event but it would later become clear it would not meet the DSM-V definition (such as seeing something on TV). Some children would not meet criteria because they did not have any intrusive symptoms, but would have trauma-related psychotic symptoms picked up in section R/Q.	We recommend two additions to ensure adequate and non-intrusive assessment of trauma: firstly, to explore doubts about the content of traumatic exposure with parents and rely on their reports of traumatic events the child has been exposed to (such as when a child declines to describe the event or the content is unclear); and secondly, when a potentially traumatic event is described elsewhere (such as physical abuse) PTSD questions should be explored even if the child and parent did not identify a specific event as traumatic. We also recommend taking a broader perspective on trauma and **including trauma-related intrusive hallucinations** (picked up in section R/Q, such as seeing dead bodies, or hearing screaming) in this section.

Section, version & item		Challenges	Recommendations
L & M – Alcohol and substance use disorders			
V6.0	V7.0.2		
Screening questions		Few cases of alcohol or substance use were reported, and no cases met criteria for a substance use disorder, which we believe is likely to reflect the shame and stigma associated with alcohol and drug use rather than low use.	Direct questions about alcohol and substance use are unlikely to illicit any honest conversations about use, let alone problematic use, and we suggest that these difficulties can only be assessed after a trusting relationship has built over time. One-time screening questions are likely to be ineffective.
N – Tic disorders			
NA	NA	No cases to report	
O – Attention deficit hyperactivity disorder			
V6.0	V7.0.2		
O2	N2	Many children screened positively for symptoms of ADHD, particularly inattention, but also met criteria for PTSD and depression, with overlapping symptoms.	We recommend careful assessment of early developmental history and pre-war symptoms when possible, and the use of clinical observation. We advise caution in assigning an ADHD diagnosis when there is co-morbidity and limited developmental information.
O4 (7 years old)	N4 (12 years old)	For V6.0 assessing symptoms prior to 7 years old was challenging because children could not remember, and parents could not be sure because children do not start school until 7, when symptoms often become clear. In addition, prior to 7 years old most children were living through the war in Syria, and it was difficult to differentiate between stress and neurodevelopmental attention difficulties.	V7.0.2 change to assessing prior to 12 years old is easier to measure, but we are concerned that ADHD could be over-diagnosed because of the timing of childhood development and the onset of the war, and the interacting symptoms of trauma, depression and anxiety, which makes neurodevelopmental disorders difficult to distinguish from acute psychological distress.

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O5	N5	Many children were not in school, and even for those in school teachers rarely fed back on individual children's progress to parents. We therefore had to rely on the one setting of home to assess functioning.	Due to the difficulties in assessing other settings and early development, **we recommend using these questions to inform only a 'possible' or 'cannot be ruled out' diagnosis**, in the same way as autism (X).
P – Conduct disorder			
V6.0	V7.0.2		
P2	O2	Child and parent reports were often different for conduct related questions, with children tending to under-report compared to parents.	For conduct problems in particular, parent and child reports should be taken into consideration when assigning a final diagnosis.
P2a,b,c,d,e,m	O2a,b,c,d,e,m	Many children screened positively for items related to fighting, hurting cats, and staying out late. However, with further exploration, the majority of children's behaviors were in keeping with the normative behaviors in the ITS, where fighting, even with sticks, throwing rocks at cats, and staying out late is commonplace, especially for children with no access to school and living in poor conditions.	We recommend exploring the content of the reported behaviors, and comparing them to the social norms in the context the child is living in. We strongly encourage the **addition of the question 'do you engage in these behaviors above and beyond other children your age?'** which we have found to be crucial in differentiating conduct problems from contextual antisocial behaviors. The question P3/O3 on whether these behaviors cause problems at home or school is grossly insufficient in this population, and we are concerned that conduct disorders risk being over-diagnosed (and normative behaviors pathologized). For animal cruelty, we also **added follow up questions to establish severity of the cruelty, such as whether the child was alone, and whether they enjoyed harming the animal** with the aim of differentiating violating social rules from joining in with peers' behaviors.

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P2f,g,l	O2f,g,l	Questions about stealing often caused offense, and assessors often had to re-iterate that these are standard questions asked to everyone, and that no-one has accused them or their child of stealing.	Assessing stealing should be done sensitively, and parents reassured that these questions are standard and pre-written.
		Assessors *refused* to ask about whether a child has forced anyone to have sex. Assessors reported that asking such questions could put the child in danger, that could at best cause embarrassment and at worse shame and stigma that could lead to the child being ostracized by the community.	**Questions on forced sex should be omitted to protect child welfare**, and any sexualized behaviors assessed within the context of a child protection evaluation with safeguards in place.
NA	NA	Assessors also noted that parents commonly reported excessive video gaming when asked about behavioral difficulties, specifically playing PUBG for up to 7 hours a day.	Whilst clearly not meeting criteria for a conduct disorder, nor being contextually different from the norm (where many children are not in school nor have access to safe outdoor play areas), the excessive gaming was concerning for parents and assessors, and referred for further support.
Q – Oppositional defiant disorder			
V6.0	V7.0.2		
O1	N1	As most children in this sample were not in school, it was often difficult to differentiate problematic behaviors from the common low level behavior disturbance related to lack of activity and structure.	As with conduct disorder, it was crucial to identify other situations when the behaviors occurred, and their severity in relation to other children of the same age in the same context.
R – Psychotic disorders			
V6.0	V7.0.2		
		In 4 of the 6 cases that reported psychotic symptoms it was clear that the symptoms were trauma related (hearing sounds of bombings, shooting, or people screaming, or seeing blood or dead bodies).	As for PTSD, we recommend taking a broader perspective on psychosis in the context of a trauma presentation. We recommend adding a **note to consider these symptoms as part of a PTSD presentation in order to prevent alarm or inappropriate treatment.**

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		For the two cases with psychosis symptoms not explained by PTSD or co-morbid with PTSD, we had difficulty finding mental health professionals to refer to with training and experience in treating at-risk of psychosis populations.	We also recommend specifically identifying **referral routes for adolescents presenting with prodromal or attenuated symptoms** of psychosis before conducting assessments.
S,T – Eating disorders			
V6.0	V7.0.2		
		We had two cases who screened positively for anorexia nervosa. However, we could not establish BMI scores based on parent report only. Parents did not have the means to measure their child's height and weight, and we initially had to rely on the parent's guess and how the child appeared.	We recommend to have a weighing scale and tape measure on hand in case children screen positively for anorexia nervosa.
U – Generalized Anxiety Disorder			
V6.0	V7.0.2		
NA	NA	Many children superficially met the criteria but the content of the worry was entirely linked to co-morbid conditions, most commonly to separation anxiety disorder or PTSD.	It is helpful that GAD is assessed towards the end of the MINI Kid so that co-morbid conditions can be taken into account. GAD was only assigned as a diagnosis when the worry was not entirely explained by other conditions.
V – Adjustment Disorder			
V6.0	V7.0.2		
NA	NA	Many children superficially met the criteria but also met the criteria for another disorder, typically PTSD, and it was therefore not assigned (or was removed after supervision).	In training, the rule out of other disorders needs to be explicit so that assessors do not automatically assign it when criteria is met.

Section, version & item		Challenges	Recommendations
W – Medical rule out			
V6.0	V7.0.2		
W1b	W1b	The answer to questions about medical illness were answered easily, but were entirely reliant on self-report from participants with poor access to medical care.	The ability to access medical care should be taken into consideration when assessing possible medical issues, and **physical symptoms should be referred for medical care before ruling them out** as medical in nature.
X – Pervasive Development Disorder			
V6.0	V7.0.2		
NA	NA	No child screened as possible PDD on the MINI Kid in this sample, which may have been due to lack of details on early childhood development and high co-morbidity. Only one case presented with autism features and this was picked up in treatment, not during the assessment.	PDD, like ADHD, is difficult to screen for using the MINI Kid in this population, and is likely to become clearer after multiple hours of client contact and observation.