How to Run a Co-Creation Workshop with Children and Adolescents on Digital Mental Health

The MEDViEW–CERTAIN Model for AI-Supported Mental Health Innovation

Who This Guide Is For: This practical guide is for researchers, healthcare professionals, designers, developers, and facilitators who plan to involve children and adolescents in the co-creation of digital mental-health tools. It translates MEDViEW's human-centred knowledge-valorisation and co-creation approach into a safe, age-appropriate and repeatable workshop model, illustrated by the University of Maribor (UM) and University Medical Centre Maribor (UKC Maribor) activities under MEDViEW[1] and CERTAIN[2]. The guide focuses on children and adolescents with mental-health-related experiences and their parents or guardians. It should be used together with local ethics requirements, clinical safeguarding procedures, and the approved research protocol. It is a methodological learning material, not a clinical intervention and not a substitute for professional mental-health care.

The Workshop in Brief: The workshops explored how children, adolescents and parents understand and evaluate AI-supported tools for the early assessment and monitoring of mental-health risks. The central questions concerned trust and transparency, fairness and bias, and privacy and control over personal data. The UM–UKC Maribor model used separate sessions for younger adolescents aged 12–14, older adolescents aged 15–20, and parents or guardians, with the content adapted to age and participant role. The model is a **co-creation activity**, not a lecture: participants are invited to influence how a future system should work, what it should explain, who should have access to data, and what safeguards are necessary. The outputs should therefore become actionable design requirements for technical, clinical and ethics teams.

Guiding Principles

- **Children are contributors, not test subjects.** Their experiences and preferences should influence design decisions.
- **Mental-health discussions require psychological safety.** Participants must never be pressured to disclose symptoms, diagnoses or personal experiences.
- **Age adaptation means redesign.** Younger and older adolescents should not receive the same questions, examples or level of abstraction.
- **Separate perspectives before combining them.** Adolescents and parents have complementary but different roles and should be heard in separate tracks before synthesis.
- **Human oversight remains central.** AI is discussed as a support tool; it does not replace a clinician or make a final diagnosis.
- **Every contribution needs a route into design.** Feedback should be recorded as requirements, risks, preferences, safeguards or questions for further investigation.

[1] EU project MEDViEW: https://medview-project.eu/
[2] EU project CERTAIN: https://certain-project.eu/

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Step 1: Define the Design Purpose

Write one clear sentence describing what the workshop must help the project decide. Avoid broad aims such as "get opinions about AI." A precise purpose determines the participant groups, questions, activities and analysis method.

Example of purpose (MEDViEW–CERTAIN model): to understand what makes AI-supported early mental-health assessment trustworthy, fair, explainable and acceptable to adolescents and parents, and to identify the conditions under which such a system could be used safely in clinical practice.

Translate the purpose into questions that can be answered during the session:

- What would make participants trust or distrust an AI-supported system?
- What explanation would they expect before accepting an AI-supported recommendation?
- Which groups could be treated unfairly, and how should this be checked?
- Who should access the data, for what purpose, and with whose consent?
- Which decisions must remain with a human professional?

MEDViEW methodology connection[3]: D03 - Knowledge Valorisation Methodologies, and MBB2 - Value-Sensitive Design and Co-Creation.

Step 2: Establish the Clinical and Ethical Framework

Obtain the required ethics approval before recruitment and prepare plain-language information and consent materials. Explain that the workshop does not assess the participant's mental health, does not collect clinical data for diagnosis, and is voluntary. Participants must be able to decline a question, skip a video or leave the session without disadvantage. For minors, obtain the required consent from a parent or legal guardian and assent from the young participant in a form they can understand.

Example (MEDViEW–CERTAIN model): In the UM–UKC Maribor study, the research protocol specified written informed consent, anonymisation or pseudonymisation procedures, restricted access, and a defined retention schedule. Local law and the approved protocol always take precedence over this guide.

Prepare a safeguarding plan before the first workshop:

- Identify a psychologist or physician experienced in working with children and adolescents who can be present or immediately available.
- Pre-screen all videos, scenarios and images for age appropriateness and potentially distressing content.
- Explain at the beginning how participants can pause, take a break or stop.
- Agree in advance how significant distress or a disclosure of risk will be handled.
- Provide information about available support and referral routes.

[3] MEDViEW methodology details available in *Zdolšek Draksler & Mlakar, 2026a; 2026b* (see references)

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MEDViEW methodology connection: D09 - Stakeholder Engagement Practices; D10 - Co-Creation and Participatory Design.

Step 3: Recruit Through Trusted Clinical or Community Partners

Recruit participants through trusted intermediaries who already have an appropriate relationship with the target group, such as a child and adolescent psychiatry service, school counselling service, patient organisation or youth-support organisation. Recruitment should never make participation appear compulsory or connected to access to treatment.

Example (MEDViEW–CERTAIN model): The UM–UKC Maribor workshops series took place at the Child and Adolescent Psychiatry Unit of UKC Maribor in June–July 2026. For our model, we distinguished three participant groups (rather than treating "young people" as one homogeneous category):

Group	Recommended format	Why the distinction matters
Children/ Younger adolescents, 12–14	Small group of approximately 5–6; about 60 minutes	Concrete language, simpler scenarios and strong visual support
Adolescents, 15–20	Small group of approximately 5–6; about 60 minutes	More analytical discussion and more complex cases can be introduced
Parents or guardians	Individual or paired discussion; about 30 minutes	Allows discussion of caregiving, trust, privacy and monitoring concerns without the child present

MEDViEW methodology connection: D09 - Stakeholder Engagement Practices; and MBB2 - Value-Sensitive Design and Co-Creation.

Step 4: Prepare a Modular Workshop Structure

Use a common structure but rotate the thematic content so each session remains manageable.

Example (MEDViEW–CERTAIN model): In the UM–UKC Maribor model, every adolescent and parent session included **trust and transparency**, plus either **fairness and bias** or **privacy and data control**. This modular approach allows the full research topic to be covered across several short sessions without overloading participants.

Example: Parent session (approximately 30 minutes)

Phase	Time	Activity
Welcome and explanation	5 min	Clarify the purpose, voluntary nature and non-clinical character of the discussion
Video or scenario introduction	5 min	Present the same core concept in an adult-oriented format

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Phase	Time	Activity
Semi-structured discussion	15 min	Explore trust, explanations, fairness, privacy, data access and clinical responsibility
Closing reflection	5 min	Capture the most important condition for safe and acceptable use

Example: Adolescent session (approximately 60 minutes)

Phase	Time	Activity
Welcome and safety briefing	5–10 min	Explain purpose, voluntary participation, confidentiality limits, and the right to pause or skip
Short video or scenario introduction	5–10 min	Present a simple, fictional example of AI use in child and adolescent mental health
Trust activity	10–15 min	Use the Trust Thermometer to collect an initial reaction and begin discussion
Rotating topic activity	15–20 min	Use Fair/Unfair Cards or the Data Journey activity
Group discussion	10–15 min	Explore reasons, concerns, desired safeguards and human oversight
Closing reflection	5 min	Ask what designers, clinicians or decision-makers should remember

The parent track does not need to replicate the adolescent activities. A focused discussion is appropriate when the aim is to understand parental expectations, concerns and decision-making responsibilities.

MEDViEW methodology connection: D08 - Capacity Building Approaches; MBB2 - Value-Sensitive Design and Co-Creation.

Step 5: Adapt the Language and Activity to Age

Use the same underlying themes but change the language, examples and expected response. Younger adolescents should be able to respond through concrete situations and visual choices. Older adolescents can discuss uncertainty, accountability, data governance and the difference between equality and fairness in greater depth. Neither group should be required to talk about their own diagnosis or treatment.

For younger adolescents, 12–14

- Use short sentences and explain unfamiliar terms immediately.
- Present fictional situations.
- Use stickers, cards, scales, drawings and role cards.

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- Offer verbal, written and non-verbal ways to respond.

For older adolescents, 15–20

- Introduce more complex scenarios involving uncertainty, unequal performance across groups, data reuse and human responsibility.
- Ask participants to propose improvements, safeguards or explanations.
- Discuss whether an AI output should be a warning, a recommendation or only an additional opinion.
- Invite participants to consider who should be accountable when the system is wrong.

For parents or guardians

- Focus on the child's well-being, family responsibilities and trust in clinical use.
- Ask when an alert would be helpful and when it would feel intrusive or alarming.
- Explore what parents would need to know about the data, the model's uncertainty and the clinician's role.
- Avoid implying that a parent is responsible for detecting or managing a child's mental-health condition alone.

Key rule: adapt the activity, not only the wording. A technically accurate adult questionnaire may still be unsuitable for a child co-creation session.

Step 6: Co-Creation Activities

Develop activities for co-creation workshops.

Example (MEDViEW–CERTAIN model): Activity 1/ Activity 2/ Activity 3

Activity 1

Trust Thermometer: Participants place a sticker or mark on a visual scale to show how much they would trust an AI-supported system in a given scenario; older adolescents can also write down one main reason for their position.
Theme: trust and transparency.
Materials: a large scale from "do not trust" to "trust completely," stickers or markers, and fictional AI scenarios.
Procedure:

1. Explain that there are no correct answers.
2. Read or show one fictional scenario at a time.
3. Ask each participant to mark how much they would trust the system in that situation.
4. Invite participants to explain their choice if they wish.
5. Record what would increase or reduce trust.

Questions to explore:

- What would the system need to explain?
- Should the doctor be able to disagree with it?
- How should the system show that it might be uncertain?
- Would you trust it more if a person checked the result?

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Activity 2

Fairness cards: participants sort scenario cards into "fair" and "unfair" categories; older adolescents can additionally suggest how an unfair system could be improved, for example through more diverse training data, additional testing, or stronger youth involvement in development.
Theme: fairness and bias.
Materials: short fictional scenario cards and two categories: "fair" and "unfair."
Procedure:

1. Present scenarios involving different ages, genders, languages, cultural backgrounds, socio-economic circumstances or disabilities.
2. Ask participants to place each card in the category that best reflects their view.
3. Ask why the situation might be fair or unfair.
4. For older adolescents, ask them to write or state one improvement.

Questions to explore:

- Could the system work better for some people than for others?
- Which differences between people should matter, and which should not?
- Who should check whether the system is fair?
- What should happen if a person believes the system treated them unfairly?

Activity 3

Data Journey: participants build a visual path showing how data move between the user, app, storage, clinician, AI system, researchers, and developers, and then identify points where privacy risks or misuse may occur.
Theme: privacy and control over data.
Materials: role cards representing the user, psychiatrist, psychologist, research team, app developer, insurer and public authority; arrows or string; consent markers.
Procedure:

1. Introduce a fictional data journey without using participants' real information.
2. Ask participants to arrange who may access which data and for what purpose.
3. Mark where explicit consent should be required.
4. Mark uses they would not accept.
5. Discuss how participants should be informed about access, storage, sharing and deletion.

Questions to explore:

- Who should see the information first?
- Should researchers use anonymised data to improve the system?
- Should users be able to see who accessed their data?
- Which uses of mental-health data should never happen?

All completed visual materials should be photographed or digitised promptly, then anonymised in accordance with the approved data-management plan.

Step 7: Facilitate Without Diagnosing or Leading

The facilitator's role is to create the conditions for meaningful input, not to defend the technology or interpret a participant's mental health. Use neutral prompts such as *"Can you tell us more about*

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that?" or *"What would make that feel safer?"* Avoid correcting opinions unless clarification is needed to prevent a misunderstanding about the fictional scenario.

Practical facilitation behaviours include:

- Speak about fictional users and situations rather than asking for personal histories.
- Give quiet participants time and an alternative way to respond.
- Prevent one participant from dominating the discussion.
- Validate the contribution without agreeing that every suggestion is technically feasible.
- Distinguish between a participant's preference, a clinical requirement and a legal or safety constraint.
- Remind participants that the system should support, not replace, qualified healthcare professionals.

For small adolescent groups, one facilitator can lead while another observes, manages materials and notices signs of discomfort. For parents, one or two trained researchers can conduct the discussion.

Step 8: Convert Contributions into Design Requirements

Immediately after each session, transform raw comments and visual outputs into a structured requirements table.

Example (MEDViEW–CERTAIN Model): MEDViEW knowledge valorisation becomes useful to CERTAIN's technical and ethics work.

Participant input	Interpreted requirement	Responsible team	Follow-up
"I need to know why it gave this warning."	Provide an understandable explanation of the factors contributing to an output.	Technical/UX	Test explanation with young users
"The doctor should decide in the end."	Keep human clinical oversight and the ability to reject an AI recommendation.	Clinical/technical	Define workflow
"Some groups might be misunderstood."	Test performance across relevant demographic and linguistic groups.	Technical/ethics	Define fairness checks
"I want to know who saw the information."	Provide an access history or equivalent transparency mechanism.	Data governance	Confirm legal feasibility
"Do not send every small change to parents."	Define proportionate alert thresholds and privacy boundaries.	Clinical/UX	Discuss with families and clinicians

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MEDViEW methodology connection: MBB2 - Value-Sensitive Design and Co-Creation; and D07 - Research-to-Practice Translation.

Step 9: Protect Participants During and After the Session

Build a short check-out into every session. Ask whether the participant feels comfortable, whether anything was upsetting, and whether they have questions about what happens next. Do not ask participants to evaluate their own mental-health condition as part of the co-creation activity.

If a participant shows significant distress:
1. Pause the activity and offer a private conversation with the trained psychologist or physician.
2. Ask whether they want to continue, take a break or leave.
3. Follow the pre-agreed safeguarding and referral procedure.
4. Inform a parent or guardian when required by the protocol and the participant's age or safety situation.
5. Record the event according to the approved ethics and data-management procedures.

The session should be considered successful even if a participant chooses not to answer or decides to stop. Voluntary withdrawal is a protected participant choice, not a failed outcome.

Step 10: Analyse Each Group Before Synthesising

Analyse different groups perspectives separately before combining them.

Example (MEDViEW–CERTAIN Model): The study protocol specifies *Reflexive Thematic Analysis*, combining deductive coding based on trust, fairness/bias and privacy/data control with inductive coding of themes emerging from the data.

A practical analysis sequence is:
1. Familiarise the team with transcripts, notes and visual outputs.
2. Code meaningful statements and decisions without reducing them to simple counts.
3. Group related codes into candidate themes.
4. Review whether each theme is coherent and distinct.
5. Produce a separate summary for each participant group.
6. Compare agreements and differences across groups.
7. Translate the findings into technical, clinical, ethics and communication requirements.

Report dissent and uncertainty. A small number of participants may identify a safety concern that is highly important even if it is not the most frequently mentioned view.

Step 11: Close the Co-Creation Loop

Co-creation is incomplete if participants provide input but never learn how it was used. After analysis, prepare a short plain-language feedback message explaining:
- What the project heard.
- Which suggestions will be taken forward.
- Which suggestions require further testing or cannot be implemented, and why.
- How privacy, fairness, safety and human oversight will be addressed.

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When the prototype changes, invite a new group or, where ethically and practically appropriate, previous participants to review whether the change responds to the original concern. This creates an iterative cycle from participation to design to validation.

MEDViEW methodology connection: MBB2 - Value-Sensitive Design and Co-Creation; D07 - Research-to-Practice Translation; and D09 - Stakeholder Engagement Practices.

Practical facilitation sequence

A clear and repeatable facilitation structure can help future organisers implement the workshop more consistently:

1. Welcome participants and explain the purpose of the session.
2. Emphasise voluntary participation, confidentiality, and the right to skip a question or stop at any time.
3. Present a short video or fictional scenario as a neutral entry point.
4. Summarise the key message in age-appropriate language.
5. Conduct one interactive activity using stickers, cards, posters, or role-based materials.
6. Facilitate a guided discussion with open questions.
7. Close with a short reflection and thank participants for their contribution.

Checklist

Before the workshop

- Plain-language participant information sheet.
- Consent and assent forms appropriate to age and local requirements.
- Parent or guardian consent procedure for minors.
- Facilitator script and semi-structured question guide.
- Age-appropriate fictional scenarios and pre-screened videos.
- Materials for co-creation activities (e.g., Trust Thermometer scale with stickers).
- Safeguarding and adverse-event procedure.
- Secure recording, storage and anonymisation plan.

During the workshop

- Consent check.
- Brief explanation of voluntary participation and the right to stop.
- One trained facilitator for each small group where possible (or more).
- Psychologist or physician present (or at least immediately available).
- Notes on verbal contributions and activity outputs.
- No collection of unnecessary clinical or identifying information.

After the workshop

- Participant well-being check and debrief.
- Secure digitisation of visual materials.
- Anonymisation or pseudonymisation according to the approved protocol.
- Separate summaries for each participant group.
- Requirements table for technical, clinical and ethics teams.
- Plain-language feedback plan for participants and families.

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Quick-Reference Checklist

- [ ] Define one concrete AI design question and several answerable research questions.
- [ ] Secure ethics approval and prepare accessible consent and assent materials.
- [ ] Recruit through a trusted clinical, community or youth-support partner.
- [ ] Separate different groups (e.g., younger adolescents, older adolescents and parents/guardians).
- [ ] Adapt activities for developmental stage; do not merely simplify adult materials.
- [ ] Avoid personal symptom disclosure and use fictional scenarios wherever possible.
- [ ] Include a trained psychologist or physician and a clear safeguarding procedure.
- [ ] Capture contributions as requirements, risks, preferences and safeguards.
- [ ] Analyse each participant group separately before synthesising.
- [ ] Feed findings to technical, clinical and ethics teams.
- [ ] Communicate back to participants how their input influenced the next design iteration.

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