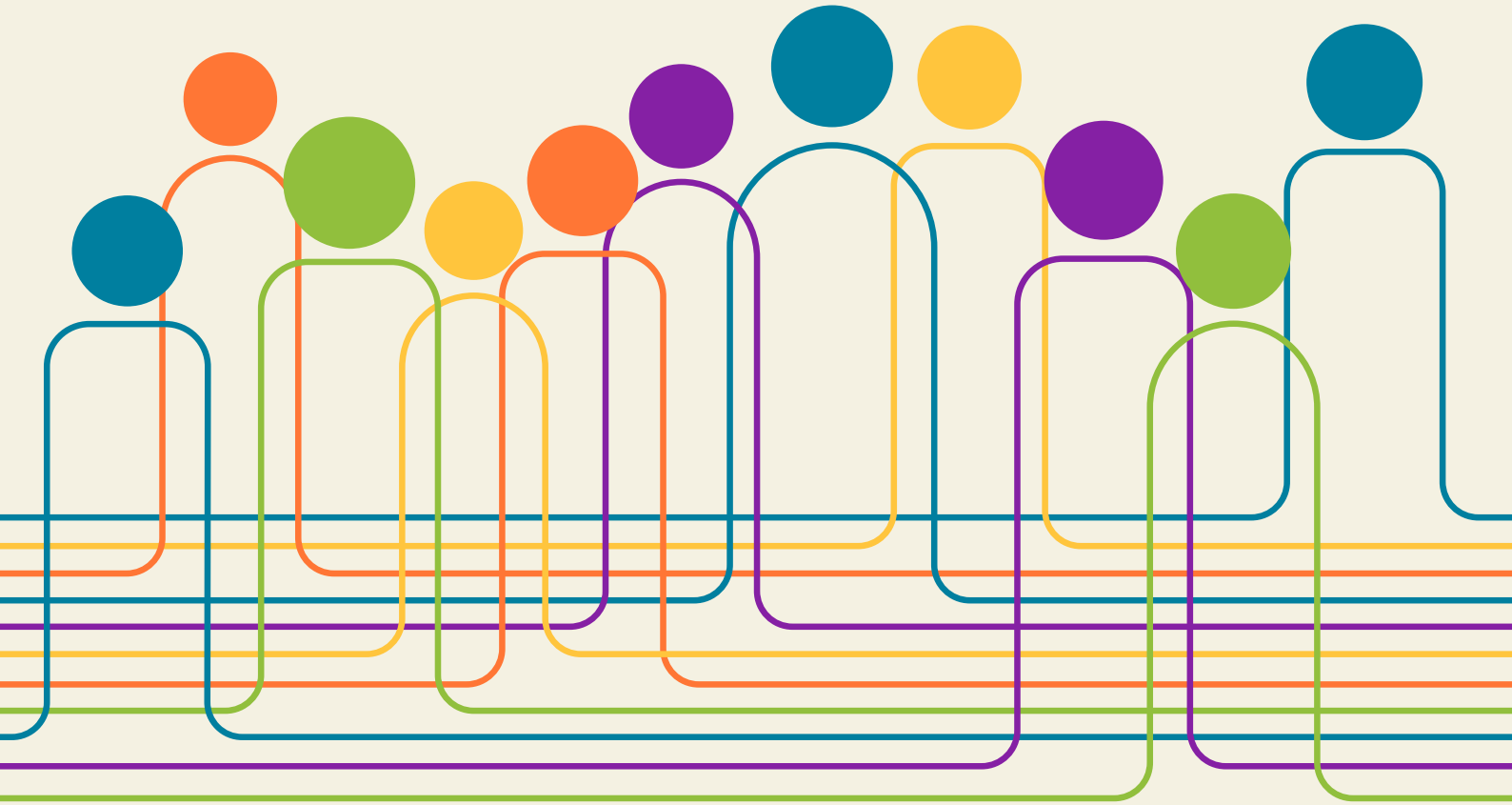
Design With
People in Mind

Dignity by Design



Design in
Mental Health
Network

Welcome to the Research and Education Workstream of the Design in Mental Health Network, UK. We are committed to developing evidence-based resources that inform decision making, support better design, and contribute to improved mental health outcomes.

Contents

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Dignity by Design

Over the past decade, the DiMHN research booklets show how mental health environments are active components of care, and when these environments are designed using a combination of objective evidence and lived experience, they can significantly improve outcomes for both patients and staff.

The first edition of 'Design with People In Mind', shows how relationships between people and places are intertwined, and describes how design can influence our behaviour, emotional states and social interactions. This booklet makes a clear case that inpatient settings should be conceived as therapeutic environments in their own right.

This thinking is developed further in a series of booklets, the next one focused on Sound, which explores the often-overlooked role of how acoustics plays a significant part in our mental state. Sound is framed as something that directly affects stress, sleep and levels of agitation. The booklet describes how careful control of noise and the introduction of positive soundscapes can contribute to wellbeing, reduction of stress, and impact on reducing violence and aggression.

The 'Stakeholder Engagement Toolkit' came next which examines how environments are conceived and delivered. This booklet provides practical methods for involving service users, carers and staff in the design process, and highlights how meaningful participation leads to better design for all. This emphasis on lived experience involvement is emphasised with our 'Nature' edition, which summarises the research which proves that access to outdoors, fresh air and natural elements can reduce stress and support recovery.

'Borders and Boundaries' was borne out of the wider populations' experience of 'lockdowns' during the Covid pandemic and examines how physical and psychological thresholds, such as walls, doors and lines of sight shape experiences of privacy, autonomy and control. It highlights the delicate balance required between observation and independence in mental health settings. 'International Edition' broadens the discussion further by presenting case studies from different countries, illustrating how diverse cultural and systemic contexts influence design approaches while still reflecting shared challenges.

Most recently, the booklet called 'Key Evidence' consolidates the current series of booklets by consolidating a set of core design principles for good design in mental health. The booklet suggests a move towards a more standardised and evidenced based understanding of what a supportive mental health environment should be, reinforcing the overarching message that design, when informed by research and lived experience, is fundamental to delivering safe and effective care.

In this latest edition, 'Dignity by Design' we build on the previous editions and lay out our understanding of how mental health support can expand beyond clinical interactions and interventions. We take a broader view beyond just mental health and consider the evidence, practical application and impact of dignity as a central concept in many parts of our daily lives. We look at how everyday journeys and spaces from public spaces, journeys through to navigating healthcare settings can be approached to take account the lived experiences that shape how people engage with space either positively or negatively.

These principles apply wherever people have limited choice about the spaces they occupy; in hospitals, care homes, schools, prisons, and other institutional settings where design decisions shape daily experience. The evidence base in this booklet is reviewed primarily within the context of mental health inpatient and community settings, but the underlying argument that design either respects or diminishes the people within it, holds across all these contexts.

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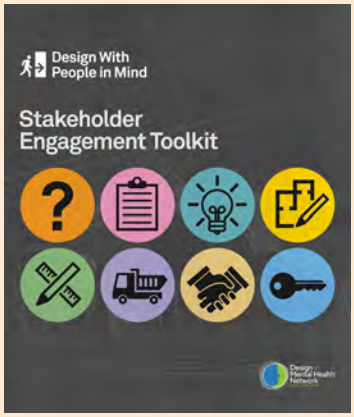

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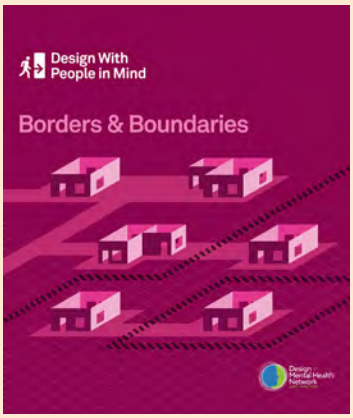

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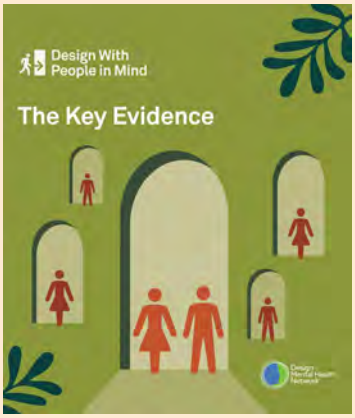

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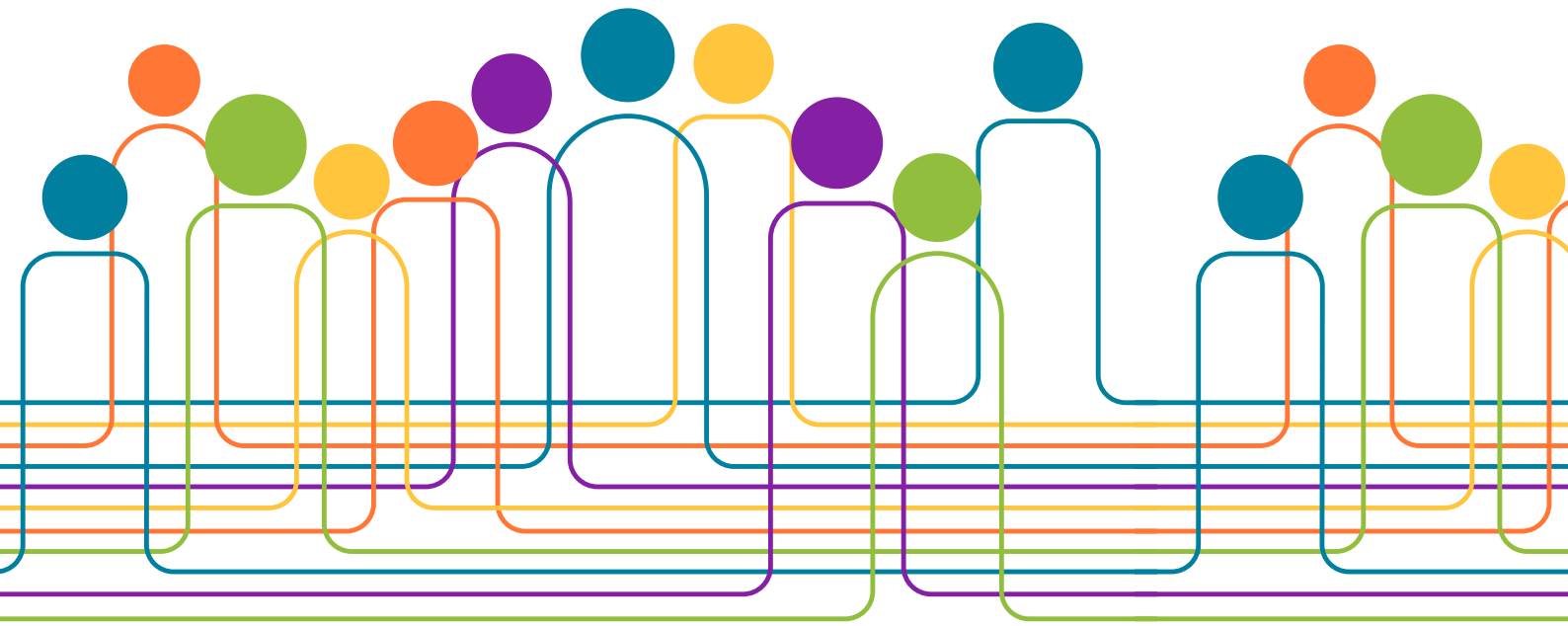
Defining Dignity

Few concepts carry as much moral weight or provoke as much disagreement as dignity. At the heart of this debate is a longstanding tension between viewing dignity as inherent to all people and understanding it as shaped by the conditions in which they live.

Early accounts frame dignity as the recognition and respect of individual worth and agency. It is something to which all humans are entitled simply by virtue of their humanness and is essential for enabling self-realisation, equality, and meaningful life. Immanual Kant (Herbert, 1999) reinforced this view by emphasising that dignity requires treating people as ends in themselves, not merely as a means to the goals, interests, or convenience of others.

During the 20th Century, this understanding of dignity became a foundational principle underpinning freedom, justice, and positive wellbeing, and was formally enshrined in international law, most notably in the 1948 United Nations Universal Declaration of Human Rights (United Nations, 1949). Yet legal recognition has not guaranteed its preservation in practice. Hatred, poverty, discrimination and other structural harms continue to strip individuals of their dignity, challenging the idea that it can be understood as universally guaranteed.

More recent perspectives understand dignity as contingent produced or undermined through social interactions, institutional practices, and material environments. From this view, dignity is not something individuals simply have, but something that is granted, upheld, or undermined through everyday encounters and structural arrangements. While it is appealing to imagine dignity as consistently afforded, it is more often recognised through its loss or violation. Such violations occur when individuals' values, preferences, and identities cannot be sustained within interpersonal relationships or broader social, cultural, and institutional contexts. Scholars emphasise that these risks are particularly acute in settings marked by asymmetries of authority and control, where individuals are rendered vulnerable and the likelihood of dignity violations is heightened.



When dignity is undermined, agency is reduced, inequalities are reinforced, and experiences of shame, stress, humiliation, dependency, and stigma take hold. These effects can weaken a person's sense of belonging, self-worth, and confidence, and discourage help-seeking during times of distress, and crucially loss of personal control is directly associated with heightened distress, withdrawal from treatment, and deterioration in mental state (Staniszewska et al, 2019). Rather than supporting recovery, these dynamics can trap individuals in cycles of mental illness and isolation an outcome that is particularly troubling given the central role of social connection in sustaining meaning, purpose, and self-worth. Understanding dignity as contingent is therefore essential for identifying the conditions under which dignity is threatened and for creating environments that promote autonomy, recognition, and empowerment for all.

> ***Dignity requires treating people as ends in themselves, not merely as a means to the goals, interests, or convenience of others.***
>
> **Immanual Kant**

Dignity in Design

Understanding dignity as contingent has become increasingly influential in design practice, reinforcing the idea that nothing in the built environment is neutral. Rather, the spaces in which people live, work, and interact actively shape whether dignity is supported or undermined.

In design practice, dignity means recognising humans not as passive recipients, but as autonomous individuals entitled to independence, agency, and meaningful participation in society regardless of class, achievement, gender, or race and the costs its realisation may entail. Designing with dignity therefore requires empathy, compassion, and attentiveness to the diversity of individual needs, as well as to how people wish to meet those needs. This is particularly important for those whose experiences are often marginalised by dominant design norms, including disabled people, those living in poverty, and women.

Human-centred design offers a key approach to embedding dignity in design. By placing people at the centre of the design process, it prioritises an understanding of users' needs, emotions, and lived experiences, enabling greater control over the spaces they inhabit. Crucially, this approach must engage with a broad diversity of perspectives, rather than that of an idealised 'average' user, as the wider the range of experiences considered, the greater the potential for design outcomes that uphold dignity.

This approach supports the creation of environments that are not only physically barrier-free and usable, but also intuitive, familiar, and easy to navigate without marking particular user groups as different. In doing so, these spaces support autonomy, enable the expression of self-image, foster empowerment in realising one's full potential, and promote social justice and equality. Therefore, the protection, promotion, and celebration of dignity must be understood as a central objective of architecture and a core responsibility of design practice.

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Dignity's Absence

Despite significant improvements in mental health design with growing recognition of the importance of human-centred design, much of the built environment continues to be shaped by regulatory, economic, and institutional frameworks that often continues to prioritise risk elimination, efficiency, compliance, and cost-effectiveness over what matters most to people with lived experience. The result is a persistence of uniform, one-size-fits-all environments that don't work as well as they could. Designed around an assumed 'typical' mental health user, these spaces embed narrow norms of size, ability, age, and appearance, reinforcing ableist and exclusionary assumptions.

The consequences are most visible in settings where dignity matters most, including hospitals, social housing, and highly exposed public spaces. For example, as Smith (2025) documents, people with physical disabilities are often required to squeeze through narrow corridors, access spaces via back entrances, or navigate filth and waste to use public facilities. Although such environments may be labelled 'accessible', they are frequently alienating, forcing people to rely on assistance, plan their movements strategically, or avoid these spaces altogether.

These design failures exclude people from full participation in public life, fostering feelings of being dirty, burdensome, morally 'out of place', and positioned at the lowest end of a hierarchy of social worth. Overtime, such experiences shape how individuals come to understand their own worth and what they can expect from society, with serious consequences for wellbeing, mental health, personal security, and livelihoods, frequently driving individuals toward social withdrawal and isolation.

As design increasingly engages with vulnerable populations, dignity must be recognised not only as an ethical concern but as a core design principle. Dignity in design is a basic human need, not a privilege. Realising it requires a shift away from narrowly functional outcomes toward environments that foreground agency, lived experience, and meaningful participation – creating spaces that signal meaningful inclusion rather than difference.

Dignity in Mental Health Inpatient Settings

If dignity violations are most acute in settings marked by asymmetry of power and control, mental health inpatient environments represent perhaps the most extreme expression of this vulnerability. People admitted to psychiatric wards often have their freedom curtailed, their routines disrupted, and their daily choices from when to lock their room to whether they can access fresh air made subject to institutional permission. These are conditions in which dignity is not merely at risk; it is structurally challenged by the environment itself.

Research bears this out with troubling clarity. A systematic review by Plunkett and Kelly, (2021) titled 'Dignity: The elephant in the room in psychiatric inpatient care?' identified recurring themes in the lived experience of inpatients: coercion, powerlessness, the care environment, relationship with staff, the impact of involuntary treatment, and persistent paradoxes between care and control. Across all themes, the physical environment its layout, its institutional character, its signals about who holds power played a consistent and often underacknowledged role in either supporting or undermining dignity. A complementary qualitative synthesis of adverse inpatient experiences confirms the interplay between systemic, environmental, and individual factors, and argues that recognising and addressing these factors can significantly enhance patient outcomes (Hallett et al., 2025).

These findings are echoed in the Care Quality Commission's annual monitoring of the Mental Health Act. The CQC's 2021–22 report identified physical environments as a site of persistent and serious concern: many wards remained in urgent need of repair, while specific dignity issues including the lack of private, lockable spaces for personal belongings, inadequate communal eating facilities, and wards operating above safe capacity were recurring findings (CQC, 2022). Bed pressures frequently resulted in people being cared for in inappropriate settings, with direct consequences for their sense of safety and respect. These are not marginal or exceptional failings; they are features of a system in which dignity has been systematically deprioritised.

Yet the evidence also points toward what is possible. Thomsen et al. (2023) documented significant improvements to patient and staff experience through a user-driven redesign of an acute psychiatric ward in Denmark. Design changes developed with service users including spaces offering contact with nature, genuine privacy, and meaningful social activity produced measurably better outcomes for dignity and therapeutic experience. Similarly, broader reviews of inpatient psychiatric design consistently demonstrate that features which support patient autonomy personal control over lighting and temperature, single rooms that can be personalised, access to outdoor space are associated with greater engagement with recovery and reduced incidents of conflict (Rodríguez-Labajos et al., 2024). The implication is clear: dignity cannot be designed in from the outside or retrofitted as an afterthought. It must be co-produced with the people who will live within these spaces. This is the foundational argument running through this publication.

Dignity in public places

The public spaces we move through each day shape our mental health. Streets, transport hubs, parks and civic buildings communicate who belongs, who is welcome, and who must adapt.

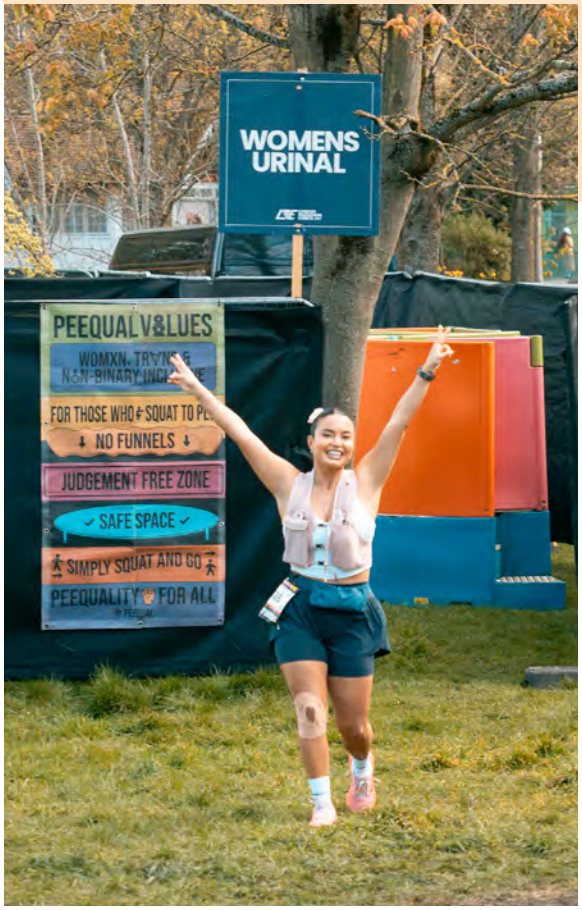
Public space is never neutral. Its layout, lighting and facilities signal expectations about bodies and behaviour. For some, these spaces are navigated effortlessly. For others, they demand constant calculation: Is it safe? Is there somewhere accessible to rest? Will I be exposed or questioned?

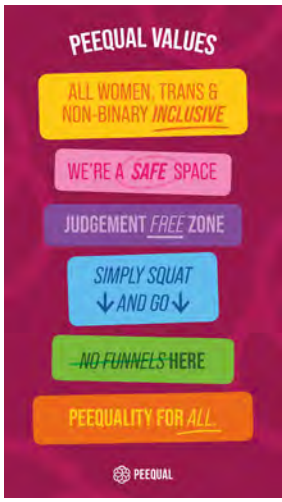
When design centres an assumed 'default' user, those who do not fit that persona carry additional cognitive and emotional labour. They may avoid certain areas, limit their time in public, or plan routes to reduce embarrassment or risk.

Dignity sits at the heart of this dynamic. It is felt in moments of ease or exposure, autonomy or dependence. When public environments undermine dignity, they reinforce shame and exclusion. When they uphold it, they foster confidence, safety and connection.

This chapter explores dignity in public places, using the example of access to public toilets and how this intersects with dignity, gender equity, belonging and thus wellbeing, and social justice. Toilets are not just functional, they are sites of visibility and vulnerability, and have, in recent years, been utilised to echo wider discussions of who has the right to be recognised by society (McGuire et al., 2021).

With women being provided half the number of toilets as their male counterparts, it is common to experience long queues, unsanitary and unsafe conditions, with women often having to make mental calculations about whether to locate another bathroom or "wait it out" (Greed, 2007; Eirich, 2023). 'PEEQUAL' is a semi-permanent woman's urinal innovation born from the recognition of the patriarchal design of public access to toilets (with women regularly waiting 34 times longer than men to use the toilets). PEEQUAL highlights how traditional toilet infrastructure privileges men through urinal access, speed, and spatial dominance, while women, trans, and disabled people often face long queues, poor facilities, or outright exclusion. PEEQUAL also reduces the likelihood of women resorting to urinating in public spaces, a convenience more readily available to men, but one that poses significantly greater risks and exposure for women.





This inequality in public planning is evident in real-world consequences, such as when a 21-year-old woman in Amsterdam was given a €140 fine for public urination, despite the staggering three public toilets for women compared to the 35 public urinals for men across the city (Ashifa, 2024). Challenging this fine, she highlighted that this affects not only women, but also people in wheelchairs, and parents of young children. This example of "sanitary sexism" sparked outrage across the country, catching the attention of an Amsterdam city councillor, who began rallying for changes within the city which eventually resulted in a €4 million investment across Amsterdam. As communicated by the woman who received the fine, "I think the city is mostly built by and for men, so if I look at it from that angle, it isn't surprising that there are only urinals for men" (Ashifa, 2024).

Bad practice

Tokenistic attempts at providing allegedly inclusive public bathrooms can lead to the creating undignified environments, in some cases leading to an increase in vulnerability and ostracism (Brown et al., 2020). This often comes in conjunction with failing to adequately consult users and stakeholders, therefore posing the risk of excluding marginalised communities or minority groups altogether (Gagan Deep, 2023). Examples of this exclusion can be seen in the experiences of people with physical disabilities having to navigate inaccessible infrastructure and how this impacts their sense of worth and dignity (Smith, 2025).

Good practice

Good practice in the design of public bathrooms emphasises dignity through inclusive design principles and community-led approaches that actively involve diverse users in shaping and producing the spaces they rely on. Relatively simple inclusive design ensures accessibility and respect for all by incorporating features such as step-free entryways, wide doorways, gender-neutral facilities, clear signage, and provisions for caregiving and menstruation. Community-led toilet projects further strengthen this commitment by engaging marginalised groups, such as disabled people, trans and non-binary individuals, and caregivers, in participatory co-design processes and ongoing feedback mechanisms. These practices not only create functional and safe environments but affirm the worth and belonging of those who have historically been excluded, utilising public bathrooms as spaces that uphold dignity and foster inclusion.

Key points:

Public spaces are not neutral, when designed around an assumed 'default' user, they reproduce inequality and undermine dignity, but when shaped through inclusive design, they can actively promote not only dignity but belonging, social justice and self-worth.

Dignity in transit

For many people, the experience of seeking help begins not at reception, but at the bus stop, on the pavement, in the car park. If that journey is inaccessible, humiliating, unsafe or anxiety-inducing, it can raise the threshold for seeking support particularly for those already experiencing distress.

As community-based services expand, the question of dignified transit becomes increasingly urgent. A service may be welcoming inside, but if it is difficult to reach, poorly connected to public transport, inadequately lit, or embedded within hostile infrastructure, its accessibility is compromised. For individuals in crisis, environmental stressors are further barriers.

Dignified transit is not simply a transport issue; it is an equity and mental health issue. When journeys to care are safe, affordable and respectful, they lower the psychological and practical barriers to help-seeking. When they are not, they reinforce inequality and exclusion.

If we accept that environments can heal or harm, then the spaces between services matter just as much as the services themselves. Designing for dignity in transit requires shared responsibility across sectors and offers a tangible opportunity to embed public mental health into the fabric of everyday life.

Whether commuting to work, going to the shop, or travelling to access healthcare facilities, transit spaces are essential to daily life. Despite this, these spaces are often designed with profit, efficiency, and control in mind, rarely considering dignity. From cramped airplane seats to inaccessible bus stops, the experience of movement can be deeply unequal.

This chapter explores how dignity is shaped, and often ignored, in transit environments. It examines how design, policy, and social norms impact who feels safe, respected, and comfortable while travelling. We also consider how gender, class, disability, and race intersect with transit experiences, revealing systemic patterns. As Kim (2021) argues, dignity is a fundamental principle of human-centred design, and particularly important in-service design, due to the collective participation of individuals with diverse needs and backgrounds.

Bad practice

Bad practice in transit design and management is evident in environments that neglect dignity in favour of operational control and profit efficiency. Airlines reducing seat sizes to maximise profit leave passengers physically uncomfortable and stripped of privacy. Another common problem faced by larger passengers on planes is their difficulty in fastening the seatbelt. Whilst airlines provide seatbelt extensions free of charge, these extensions are often brightly coloured, drawing unwanted attention and causing embarrassment when requested. This highlights how transit systems frequently privilege a smaller body type, forcing those who do not conform to disclose their needs publicly in ways that undermine dignity. Bus networks that fail to provide accessible stops exclude disabled users from participation in public life. These examples demonstrate how transit spaces can reproduce social hierarchies, positioning certain groups as less entitled to dignified movement through public space. As Kim (2021) highlights, dignity must be embedded into the human systems that govern service interactions, otherwise transit environments risk becoming sites that replicate humiliation and exclusion, rather than spaces of safe and respectful movement.

Good practice

Good practice in transit emphasises inclusive design, equitable policy, and community engagement to ensure that all passengers experience dignity while travelling. This includes designing cabins and buses with adequate space, accessible seating, and clear signage. This also looks like ensuring transport hubs are well-lit, safe, and involve universal design principles that prioritise the needs of disabled and elderly passengers. Community-led transit initiatives such as participatory planning of bus routes or consultation with marginalised groups help ensure that services reflect lived experiences rather than abstract efficiency metrics (Chapman et al., 2024; Goodspeed et al., 2023). Policies that subsidise fares for low-income travellers and train staff in cultural sensitivity and disability awareness further strengthen dignity in transit. When these practices are implemented, transit spaces shift from being sites of exclusion and discomfort, to environments that affirm belonging, respect, and equality in everyday movement.

Key point:

Transit spaces are not just systems of movement but sites where dignity is either upheld or violated. When transport is designed around efficiency, profit, and control, it reproduces inequality and exclusion. Embedding dignity into transit design through inclusive spaces, equitable policies, and respectful service interactions, is key to ensuring safe, comfortable and dignified movement for all.

Dignity in healthcare: designing for the spaces in between

Healthcare institutions can take many forms: from GP surgeries and hospitals to care homes, mental health facilities and even the newer 'pop-up' initiatives, such as the MRI units in car parks. Despite their differences, these environments share a public, exposed quality, often disconnected from the paces of everyday life. This publicness is significant because as Mathiasen and Frandsen (2017) note, no one enters a hospital entirely voluntarily.

This chapter explores dignity in clinical design, particularly within hospitals, whilst acknowledging the vulnerability of end-users across all clinical settings. Healthcare institutions, as formally defined, are inherently clinical and institutionalised; described as places for "care or treatment of patients" (MDR, 2019). This stands in contrast to the World Health Organisation's understanding of health as "a state of complete physical, mental and social wellbeing", exposing how institutional framings can diverge from the lived experience of people moving through clinical environments. Healthcare professionals stand as one of the most highly trusted groups in society (BMA, 2025) and the very language of "patient" and "treatment" reinforces a hierarchy where individuals depend on the institutions for health. Whilst the language may be appropriate in acute medical settings, it does not reflect the lived experience of those navigating these environments (Costa et al., 2019). The result is an inherent professional-patient power imbalance that shapes how people move, feel and behave in clinical spaces. For designers, this imbalance matters.

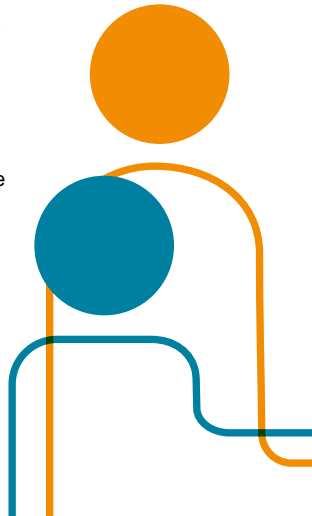
Baillie (2009) identified the inherent vulnerability of being a patient or healthcare user, noting that both the environment and professional behaviour influence whether dignity is upheld or lost. Harris (1987) examined the depersonalisation of inpatient hospital life, where certain indignities are accepted without embarrassment. In contrast, outpatients remain bound by societal taboos, anxious about their condition or appointment, and subjected to a very public walk to their destination, where feelings of exposure and indignity are intensified. These experiences highlight how design can either amplify or mitigate the emotional burden of moving through clinical environments. Whilst evidence-based design has driven improvements in health and wellbeing, much of this progress has focussed on clinical spaces such as dual or single patient rooms, increased occupant controllability and stronger connections to nature (Bernhardt et al., 2021). Yet these advances have not been applied evenly across the hospital to include circulation spaces, where vulnerability is often most exposed.

This imbalance is not only relational, it is spatial. Circulation spaces feel emotionally charged. Research on the social production of space shows that environments are never neutral: they communicate who belongs, who holds power, and who is vulnerable (Lefebvre, 1991). Clinical environments function as controlled spaces where ordinary social rules are suspended; where time slows, choices narrow, and the normal markers of identity and status can fall away. In such settings, poor wayfinding prolongs uncertainty and hesitant movement, intensifying the sense of being out of place and undermining dignity.

This becomes particularly visible in the everyday journeys patients must make from outside, bound by the taboos of society, into the healthcare institution. Each journey from a consultation room to the x-ray suite, from the ward to the toilet, from a room to a courtyard or in the most difficult circumstance from a ward to the mortuary, exposes a spatial 'otherness'. These spaces are universally felt as a 'public', where one is expected to conform to norms, suppress emotion, and keep moving towards a destination. They are neither fully private nor fully communal; they are regulated, surveilled, and socially coded.

When wayfinding fails, the corridor becomes a site of disorientation, vulnerability, and heightened anxiety and self-awareness; all conditions that intensify the uncomfortable nature of the experience. This intersects with debates on spatial justice and how dignity is allocated across social groups in public space (Azad and Boroojeni, 2025).

One example of an intervention that directly addresses these pressures is the 4Louis Privacy Pram.4Louise is a UK based child loss support charity, working nationwide



When designing, we have a societal responsibility to remove barriers to self-empowerment, autonomy and dignity within clinical settings.

with families affected by miscarriage, stillbirth, and the death of a baby or child. With the cooperation of families and healthcare teams, 4Louise identified the journey to the mortuary as one of the most difficult moments, in a very public, undignified and overwhelming experience. They developed this in response to a very public and overwhelming situation, and viewed through this lens, it highlights how architectural layouts and societal expectations may fail those who are involuntarily drawn into the hospital's most exposed spaces. The Privacy Prams is designed to provide a "safe, dignified and discreet way for babies and children to be transported within hospital settings", giving families that option of respect and soften the institutional feel of the environment This invention was developed with choice and dignity at the forefront, not to override existing processes. The thoughtful design includes a "respect my privacy" sticker and a fully wipeable insert that meets strict infection control requirements, reflect a balance between the dignity required and the clinical practicality demanded, a way of thinking that built environment designers could adopt far more widely.

This invention reminds us that meaningful improvement in these circulation spaces depends less on abstract architectural precedent and more on engaging communities, evaluating real occupancy experiences, and allowing designers to confront the discomforts and taboos, that shape lived experience. For designers, this matters because it highlights a lived experience gap, the space between what institutions expect, what users feel, and what design must respond to if dignity is to be upheld (Mathiasen and Frandsen, 2017).

Across these examples, from institutional definitions to circulation spaces to lived experience led interventions, a consistent theme emerges dignity must be designed, not assumed. We like to imagine we're always designing for good, for better futures, yet in the hospital context 'better' must also account for the difficult, the painful, and the deeply human. These environments hold illness, fear and loss alongside care, and nowhere is this more visible than in the open, in-between spaces where people must move around. When wayfinding fails, these spaces shift from merely functional to actively exposing, intensifying the sense of otherness already embedded in clinical settings. Our responsibility as designers is therefore not just to improve efficiency but to place dignity at the centre of how these spaces are shaped.

Nowhere are these spatial dynamics more heightened than in acute inpatient mental health environments. Research on psychiatric ward design demonstrates a consistent tension: settings designed primarily around risk management with open observation models, long surveillance corridors, and locked exit routes can undermine the very therapeutic outcomes they are intended to support. Spatial confinement and restriction of movement have been linked to heightened feelings of loss of control, vulnerability, and aggression among patients; in some cases, design features intended to ensure safety actively generate the distress they aim to prevent (Rodríguez-Labajos et al., 2024). A counterargument is increasingly supported by evidence: the AMA Journal of Ethics (2024) has argued compellingly that dignity preservation should be treated not as an add-on to inpatient psychiatric design, but as a precondition for therapeutic effectiveness and patient safety. Design features that give patients meaningful control; personal regulation of lighting and temperature, the ability to personalise their room, access to outdoor space, and flexible communal areas that allow for varying levels of social interaction are consistently associated with greater engagement with recovery, reduced conflict, and improved therapeutic relationships with staff (Frontiers in Psychiatry, 2022). This is not a question of comfort versus clinical function; it is a question of whether the space actively supports or undermines the fundamental conditions for recovery.

Key point:

People move through healthcare spaces shaped by societal expectations, yet these environments often feel unfamiliar, with an unspoken assumption that individuals will know how to navigate and behave. Dignity cannot be assumed; it must be intentionally designed into space. When wayfinding is poor, uncertainty is heightened, transforming places intended to support into ones that can feel exposing and disorientating.

Exploring dignity through community located health settings

Recent NHS England and government policy emphasises a shift from hospital-based to community-based care, reflecting a broader transformation towards earlier intervention, proactive population health management, and more integrated care across health, social care, and the voluntary sector (NHS England, 2024), with important implications for how dignity is experienced in these settings.

This shift in physical and mental healthcare delivery into community settings has been shown to offer a range of benefits for service users and carers. For example, delivering care closer to home can alleviate transport and accessibility barriers (Lalani et al., 2019), particularly where large hospital estates are located outside or on the edge of towns requiring travel that can be difficult and, at times, undignified for individuals experiencing distress. In addition, locating healthcare provision in community spaces is argued to normalise presentations to services in physical locations that are in familiar locations for people. As such, everyday community locations can reduce stigma/psychological barriers and support uptake, because the setting feels normal, non-clinical, and easier to approach, particularly in often stigmatized service provisions such as mental health (Baskin et al., 2023).

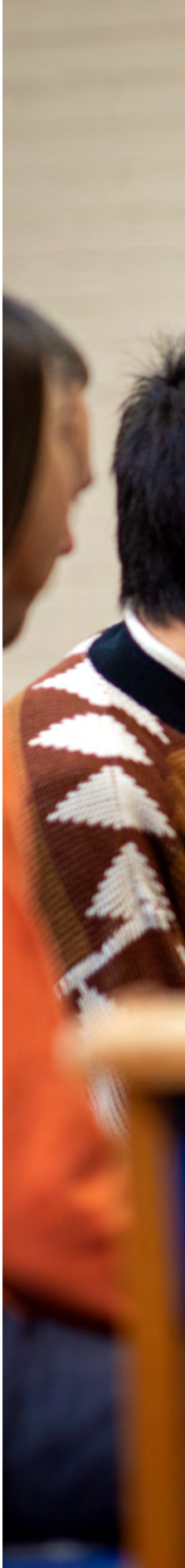
However, whilst the provision of formal healthcare in community spaces and places is a positive development, without a significant consideration for the dignity of the service user in both design and location, it can result in increased distress. For example, reflecting on years of professional visits to mental health services located in community settings there is one particular service which exemplifies the need to consider dignity in design. The example is a Child and Adolescent Mental Health Service (CAMHS) located in a Local Authority building which has historically been used for registering births, deaths, and holding marriage and civil partnership ceremonies. Due to its central location, it is easily accessible and housed in a building familiar to local communities. However, the CAMHS service is located on the first floor of the building with the ground floor still in use for registration and marriage/civil partnership ceremonies. To access the first-floor young people and their parents/caregivers need to enter the building through the main entrance, into the large open area where people are gathered for registrations or ceremonies and make their way up the grand staircase for all to see as they go to access the CAMHS service. As a result of the social stigma surrounding mental health services, particularly for young people and their parents, the experience represents one devoid of dignity and more akin to ‘a walk of shame’.

Whilst not located within community settings, Mental Health Emergency Departments (MHEDs) represent a ‘front door’ into acute crisis care, where dignity must be central to design in order to avoid replicating the stressful, overstimulating, and untherapeutic conditions often associated with conventional emergency departments (Roennfeldt et al., 2021).

With rapid delivery prioritised, for MHEDs, dignity best practice in relation to lived experience involvement and co-production that is, designing services together with the people who use them, from start to finish, rather than simply consulting them afterwards could be compromised for speed of delivery. In addition, conceptualised as ‘emergency departments’, the spaces designed could prioritise the mitigation of risk and focus on security and potentially seclusion spaces, at the expense of a therapeutic and calming environment that prioritises dignified interrelationships between healthcare professionals and those using services (Bennett & Hanna, 2021).

Key point:

Community-based healthcare can improve access, reduce stigma, and normalise engagement by embedding services in familiar settings. However, location alone is not enough - dignity must be designed into these spaces. The drive for efficiency and risk management should not overlook the calm, relational environments needed to support dignified care.



Everyday community locations can reduce stigma/ psychological barriers and support uptake, because the setting feels normal, non-clinical, and easier to approach, particularly in often stigmatized service provisions such as mental health.

(Baskin et al., 2023)

A Design for Dignity Toolkit

Practical principles for designing mental health environments that uphold dignity, autonomy and lived experience

What this toolkit is for

This toolkit is a practical resource for anyone involved in designing, commissioning, creating or evaluating environments where people receive mental health care. Its audience is deliberately broad: architects and interior designers, NHS estates and commissioning teams, clinicians, service users, people with lived experience, and anyone who wants to support an approach that improves lives through design thinking.

Dignity in design is not primarily an aesthetic consideration. It is a combination of clinical, ethical and human rights approach to human wellbeing and wellness. Research consistently demonstrates that the physical design and consequent environment of a mental health ward conveys signals about power and control and directly shapes whether people feel respected or diminished, safe or surveilled, and feeling like a respected human being or a patient. Environments designed primarily around risk management and institutional efficiency can undermine the very recovery they are trying to support.

This toolkit offers a framework for thinking about how to approach this providing a set of principles that can be applied at any scale, from a single-room refurbishment to a new hospital build, and at any stage of a project from brief to post-occupancy.

The Foundation: Lived Experience and Co-Production

At its core, designing for dignity is about centring on the lived experience voice and making the realities of design choices heard, listened to, understood and responded to.

Lived experience involvement is not one step among others, it is the foundation upon which all others rest.

Secure mental health spaces can be remarkably dehumanising, taking away the daily basics of life that we hold dear, mainly in the name of safety. Whether it is the need to ask a member of staff to unlock your bedroom, the inability to cook your own food, or simply not being able to clean your own bathroom.

Co-design and co-production are not token gestures or consultation exercises. They are the mechanism through which design can respond to actual reality of lived experience rather than precedent, professional habit or institutional norms. The Royal College of Psychiatrists is clear that meaningful co-production requires shared power, not just shared information.

What design can change, and what it cannot

The principles in this toolkit are evidence-based. But evidence also tells us that design has limits. A well-designed ward cannot fix staff shortages, therapeutic mismatch, or systemic underfunding. A thoughtfully laid-out corridor cannot undo the harm of coercive practice.

What design can do is create the conditions in which dignity becomes easier to build in at the start, and give the right environment to support the right clinical approach., this includes Spaces that are calming rather than chaotic, spaces that offer choices rather than constraints, spaces that signal respect rather than surveillance, and spaces that support staff and service users alike. Good design creates a platform for quality care and therapeutic relationships.

A note on your role as a designer

Where a design principle calls for a change that is outside your direct control; a change in staffing levels, clinical policy, or the organisation's culture, your role is still meaningful. Name the problem clearly. Make the case for the right answer. Record what the evidence says. Advocacy is part of the designer's job.

Co-production is designing together with service users and carers, not just consulting them and is the most reliable way to surface what design alone cannot fix, and to ensure that what design can fix is prioritised. Be honest about what level of involvement you're enabling; search for 'Ladder of Participation' to be more informed.

1. Design with Empathy

Empathic design must be inclusive of the full range of human experience, including people living with dementia, neurodivergent people, and those with cognitive disabilities. For people with dementia, the emotional residue of a space often outlasts conscious memory of it; design that communicates safety, familiarity, and calm can reduce distress even when explicit recall is absent. For neurodivergent people; including those with autism, ADHD, or sensory processing differences the material environment can be experienced very differently, with sensory intensity, unpredictability, and lack of private space causing significant distress. Empathic design listens for what words may not fully convey and accommodates minds that process the world differently.

One of the most powerful tools when designing for dignity is to imaginatively inhabit the experience of the space you are creating. How would you feel in this space? What would be your reaction if your child or sibling was here? What would a more humane and dignified version look like?

– Spend time in the space yourself. Visit at different times of day and including night shifts; noticing how the lighting impacts you, or how not having a key to your own room makes you feel. Look at how sound can affect behaviours. Look at how someone with dementia behaves in a space and corridor because they see and feel that space differently.

– Use first-person interviews, complaints, compliments and co-design sessions to build an emotional map of the space before making any decisions. Listen to people who have been inpatients and be open to their feedback or ideas challenging assumptions about what is 'good' or 'safe' design. Talk to staff, including domestic and porterage staff. You are learning all the time, and its enjoyable too.

– Run 'day in the life' workshops with people who live and work in the space, asking them to walk you through a typical 24 hours; what they needed, but couldn't access, what made them feel respected or undermined. Pair this with shadowing: follow the journey of a service user from admission to discharge.

– Use drawing and visual methods to surface what words alone cannot. Invite service users to sketch or use disposable cameras to document their experience; their route through a ward, the moment they felt most exposed, the corner they returned to for comfort. People often represent things visually that they would never articulate verbally: the scale of a corridor, the blankness of a wall, the distance between them and a member of staff they needed support from.

– Observe what people do, as much as you hear what they say. The IDEO design method cards include a key principle for human-centred design practice: what people say they do and what they actually do are sometimes starkly different. A service user might report feeling comfortable in the communal lounge; observation might reveal they sit with their back to a corner, avoid the nursing station's sightline, and leave the moment another person arrives.

2. Design for Autonomy

Design environments that empower people to live without needing to ask for help, permission or guidance. Clear routes, intuitive layouts and cues that reduce disorientation allow people to move at their own pace and maintain a sense of control.

For people with dementia, design is particularly important. Clear, consistent wayfinding using colour contrast, landmarks, and simple signage can reduce the need to ask for help. For neurodivergent people, clearly structured spaces with predictable layouts reduce cognitive load.

– Use sightlines, lighting and consistent visual cues to make routes clear without signage overload.

– Provide multiple ways to move through a space so people can choose quieter or quicker paths. Sometimes simply a path that avoids someone they don't get on with.

– Reduce unnecessary barriers; locked doors that the person cannot unlock themselves and opaque or confusing thresholds.

– Enable service users to control their own space; lighting (brightness and colour), temperature and access to fresh air. These micro-conditions of autonomy signal to a person in crisis that they remain the author of some part of their own experience.

3. Design for Spatial Equity

Ensure dignity is not unevenly distributed across a building or site. Corridors, thresholds, toilets, waiting areas and transitional zones all carry social expectations and surveillance pressures so using design to reduce these dynamics can make a big impact.

– Every route and space should offer the same level of comfort, light and quality.

– Reduce the feeling of surveillance by softening long sightlines, avoiding 'fish bowl' outdoor spaces and offer discreet but safe alcoves or spaces where people can pause.

– Ensure essential spaces such as toilets, waiting rooms and outdoor spaces are equally accessible, safe and welcoming for all users.

4. Design for Difficult Realities

Avoid design strategies that hide or sanitise experiences considered uncomfortable, embarrassing or taboo. Create environments that allow for emotional expression, privacy when needed, and honest acknowledgement of human vulnerability.

– Provide spaces where people can express distress or seek privacy without stigma.

– Use materials and layouts that acknowledge bodily realities rather than pretending they do not exist.

– Make support resources visible and accessible rather than tucked away or implied. If help is hard or humiliating to find, it will not be sought.

5. Design for Power Imbalances

Use design to fight institutional dominance wherever it appears; whether in a care planning meeting, access to unlock their bedroom door, or in reaching outdoor space. Consider how layout, visibility, acoustics, materials and access points can redistribute control and support a sense of agency and of self.

– Reduce hierarchical cues such as enclosed nursing stations, imposing glazed barriers or staff-only vantage points that overlook service users.

– Provide clear information at the point of need so people do not have to ask gatekeepers for basic orientation.

– Data is its own potential power imbalance. Think creatively about how to make information equally accessible to service users, as withheld knowledge can be felt as an abuse of power.

6. Design for Recovery, Not Just Safety

Safety and dignity are too often set against each other in the design of secure mental health environments, as though keeping someone physically safe necessarily requires removing their sense of agency, privacy and self-determination the evidence does not support this trade-off. Environments that prioritise therapeutic experience alongside clinical safety consistently show better outcomes: reduced incidents, greater engagement with treatment and stronger therapeutic alliances.

– Ask explicitly: what does this space say about recovery? Does the layout communicate that the person is here to be managed, or a space where they can find their way back to themselves?

– Design communal spaces that support different levels of social engagement; not just a single communal lounge where 10+ people are all expected to get along. Instead create alcoves for quiet reflection, settings for peer-to-peer connection and areas for joint activities.

– Consider what the environment communicates about a person's future, not just their present condition. Access to activity like arts, cooking skills, connection to the outside world are a key part of supporting someone in crisis prepare for their life ahead.

– Where seclusion spaces exist, apply the same dignity principles; natural light, human-scale proportions and access to sensory regulation. Seclusion must never be a restriction as grounds for withdrawing the conditions of dignity.

7. Keep Co-Production Alive Beyond the Brief

The most common failure in participatory design is not the absence of lived experience voices at the start, but their disappearance once a project gains momentum. True co-production is not an event; it is a relationship sustained throughout design, construction and in use.

– Establish lived experience involvement as a contractual requirement, not a goodwill gesture. Carefully plan how lived experience advisors will be recruited, compensated and integrated at each stage from brief through to post-occupancy evaluation.

– Create mechanisms for feedback once the space is occupied. A ward that felt right on paper may reveal unforeseen problems or solutions that create unintended consequences once it is lived in.

– Pay lived experience contributors fairly and transparently – it is emotional labour. Unpaid 'consultation' reproduces the power imbalance it claims to address. Think carefully about remunerating preparation time, as well as decompression time after contribution and ensure there is support for people who may be reliving painful and traumatic moments of their live.

– Document what changed because of lived experience input and share this publicly. Transparency about how co-production shaped decisions builds trust and sets a standard for the next project team.

A note on how to use this toolkit

These principles are intended as a set of questions to hold alongside every design decision of a project. Some will be more relevant at certain moments than others. All of them require the active, ongoing involvement of people with lived experience to give them honest and colourful meaning. It's only with the critically honest view from people with lived experience can we create the conditions for designing environments that genuinely support recovery, autonomy and dignity. You will need to build the time into your overall project planning and understand how to work with the client, so they understand what you require.

Conclusion

Dignity is not an abstract ideal, but something that is continuously produced through the environments we design and the systems we maintain. From public spaces and transit systems to inpatient mental health settings and community-based services, dignity is either upheld or diminished through everyday encounters with space.

What becomes clear is that design is never neutral. When environments are shaped around narrow assumptions, they reinforce inequality, exclusion, and stigma. When they are informed by lived experience, inclusive principles, and an understanding of power and vulnerability, they can instead support autonomy, belonging, and wellbeing.

Designing for dignity requires a shift in priorities. It asks us to move beyond efficiency and compliance alone, and to recognise the emotional, social, and psychological realities of those who navigate our spaces. It demands that we engage meaningfully with diverse experiences, confront uncomfortable truths, and take responsibility for the impact of our decisions.

Dignity must be understood as a central outcome of good design, not an afterthought. By embedding dignity into the fabric of everyday environments, we can create spaces that not only function effectively, but actively contribute to more equitable, compassionate, and supportive societies.

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Design With People in Mind

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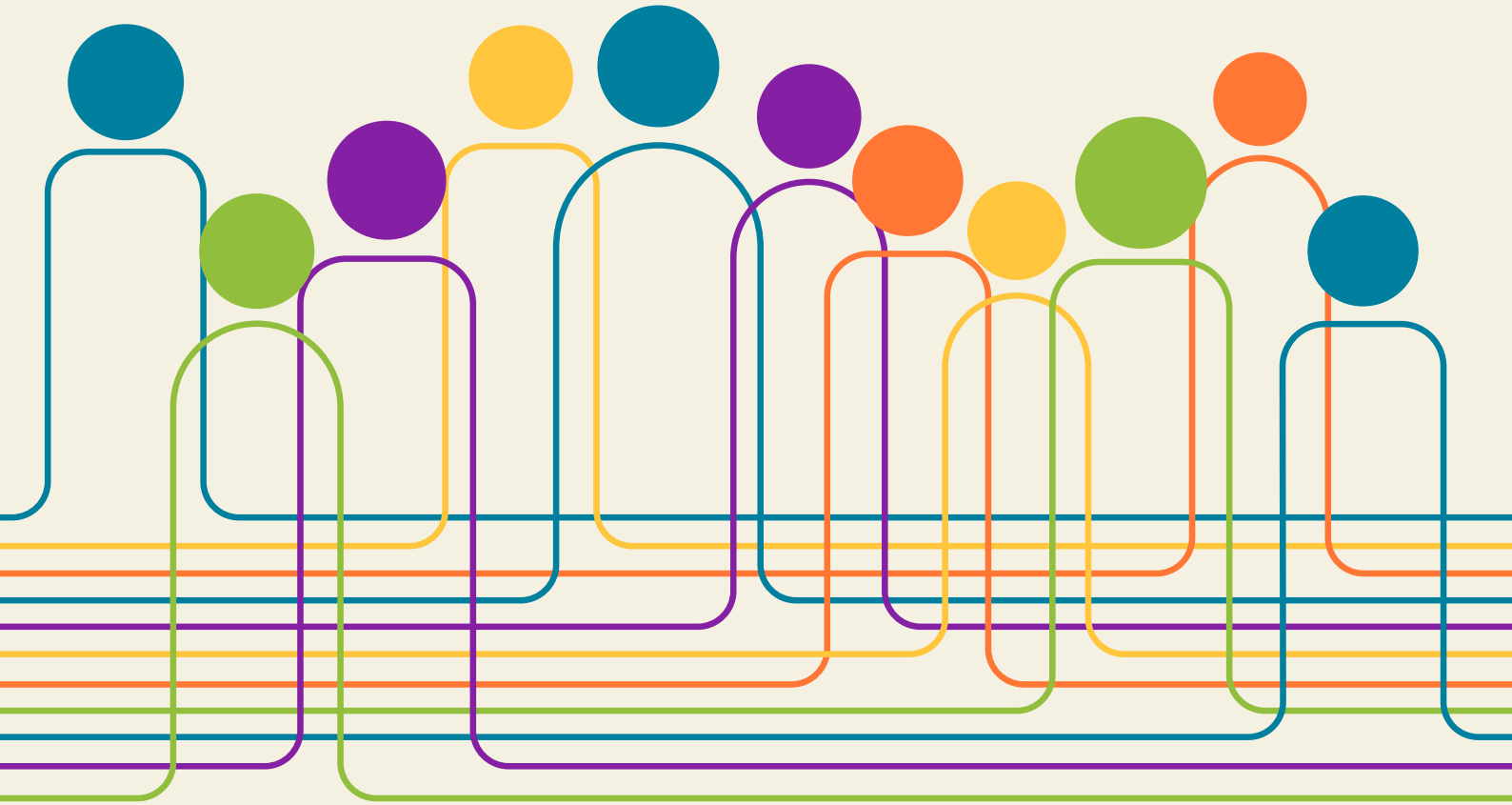

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