POSITION PAPER

The Inverse Training Law:

Why those who need training most receive it least, and what must change

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SUMMARY

In 1971, Julian Tudor Hart described the inverse care law: the principle that the availability of good medical care varies inversely with the need for it in the population served. This position paper argues that an equivalent principle, the 'inverse training law', operates throughout the homelessness and inclusion health workforce. The workers who hold the most sustained and complex relationships with people experiencing the greatest trauma, exclusion, and disadvantage receive the least structured, least theoretically grounded, and least professionally recognised training and development. This is not accidental. It reflects deep structural inequities in how training is funded, how professional identity is constructed, and whose knowledge is counted as legitimate. The consequences are borne not only by the workforce in terms of burnout, attrition, and moral injury, but by the people they serve. This paper sets out the case for a systematic response; the provision of a tiered, accessible, practice-grounded training offer that begins where the frontline workforce is and builds toward a formal recognition of sector staff expertise through provision of professional training and accreditation.

1. The Inverse Care Law and Its Legacy

In a seminal paper published in The Lancet in 1971, the Welsh GP Julian Tudor Hart described what he called the inverse care law: 'the availability of good medical care varies inversely with the need for it in the population served.' Writing from a practice in a South Wales mining village, Tudor Hart observed that the people most in need of attentive, skilled, sustained medical care, those in poverty, in industrial occupations, in poor housing, were the least likely to receive it. Resources, expertise, and professional attention flowed toward those who needed them less.

Tudor Hart's observation persists and indeed has worsened, despite GDP, medical expertise and health funding having all increased. Half a century later, it continues to be cited in debates about health inequality, workforce distribution, and the organisation of primary care. It has been extended to mental health, to dentistry, to public health more broadly. It has become a shorthand for a particular kind of systemic injustice, one that is not the result of individual malice but of structural factors that, left unreformed, reproduce disadvantage at scale.

This paper proposes a parallel formulation, specific to the homelessness and inclusion health workforce: the 'inverse training law'. The principle is this, that the quality, depth, theoretical grounding, and professional recognition of training and workforce development in

the homelessness and inclusion health sector varies inversely with the complexity of need in the populations those workers serve.

> ***The workers who are closest to those most underserved, excluded and traumatised in our society are those who systematically and structurally, are provided with the least training resource to work with them.***

This is not a criticism of individual organisations or managers. It is a structural observation about how training investment flows, whose professional development is counted as important, and what kinds of knowledge are treated as legitimate in the homelessness sector.

2. The Homelessness Workforce

People experiencing homelessness, particularly those experiencing the most complex mechanisms of exclusion, present with needs that are among the most chronic in the health and social care system. The evidence base on inclusion health populations documents extraordinarily high rates of trauma, adverse childhood experiences, mental ill health, substance use, physical health comorbidities, and cognitive deficits. Many have experienced significant violence, loss, and disrupted attachment across their whole lives. Their experiences are never simple, rarely served by single-agency remits, and rarely amenable to brief, simple or transactional responses.

Yet the people within the workforce that hold the most sustained, intensive, and in many cases significant relationships with individuals are not the consultant psychiatrists or the clinical psychologists or even the community nurses or social workers. They are the hostel support workers. The outreach team members. The floating support coordinators. These are the people who are there at the very time when a person is in crisis. Who notice that someone has not appeared for 2 days. Who sit with a person through a relapse. Who maintain relationships across years of chaos and service failure and incremental recovery.

This workforce is substantial, diverse, and largely invisible in public discourse about the health and care system. They operate across local authorities, housing associations, charities, social enterprises, and NHS-commissioned services. It includes people who came to this work through personal experience of homelessness or exclusion, people who strongly value social justice and equity, and dedicate their significant experience to improving the lives of people who have been left with almost nothing. And despite the – increasingly - emotionally demanding roles with high levels of turnover, most are low-paid and on fixed term contracts.

Crucially, it is a workforce without a unifying regulatory framework. Unlike nursing, social work or clinical psychology, there is no statutory body setting minimum training standards for people working in homelessness services. There is no protected title, no mandatory register, no CPD requirement that attaches to practice. The sector is largely unregulated in any formal sense, and training form and provision reflects that.

The expertise, value sets and resilience evidenced by the homelessness workforce is phenomenal, but all that is lost if people are not supported by systematic training and development that addressed their specific needs. Ticking boxes around training inputs is not enough.

3. What the Inverse Training Law Looks Like in Practice

What frontline homelessness workers typically receive by way of training falls into a familiar pattern. On joining a service, they receive induction training, including fire safety, safeguarding basics, medication management if relevant, lone working procedures and perhaps data protection. These are compliance-driven, tick-box in format, and largely disconnected from the relational and therapeutic demands of the work.

Beyond induction, provision varies enormously by organisation and by the resources available. Some workers will receive training in specific techniques, most often motivational interviewing or other brief interventions, and sometimes mental health first aid or similar ways of understanding complex issues. A smaller number will have access to reflective practice groups or clinical supervision. A minority will be supported to undertake more extended professional development, often driven by individual motivation rather than systematic organisational investment.

What almost no frontline homelessness worker receives, in any structured or recognised form, is training that addresses the theoretical and relational foundations of their work, e.g. attachment theory and its relevance to practice with people who have experienced profound disruption. Similarly, training in the neuroscience of trauma and how it shapes behaviour and engagement and the psychology of homelessness making use of evidence-based theory to account for individual and contextual maintenance factors is patchy, as is an understanding of the complex dynamics of relationships built in corridors car journeys rather than consulting rooms. Factors implicated in burnout should such as the limits of relentless compassion and the role of boundaries should be the basics of what is taught in our sector.

This is not because such knowledge does not exist. It does. The evidence base on trauma-informed care, psychologically informed environments, attachment and homelessness, and the therapeutic use of relationship in complex situations is substantial and growing. It is also not the fault of any individual or organisation; they are doing the best they can given the legislative, commissioning and resource drivers to which they are subject. The issue is structural; the training needs of people working in this sector are not recognised in the same way as other sectors where legislation governs professional practice.

The contrast with other parts of the system is instructive. Clinical psychologists or CBT therapists working in NHS settings are required to demonstrate continuous professional development, have access to CPD budgets, and operate within a framework of regular supervision and reflective practice. Occupational therapists, nurses, and social workers have regulatory bodies that mandate ongoing training. These are not luxuries — they are recognised as essential to safe and effective practice. The question is why equivalent provision is not considered essential for those working with some of the most traumatised people in the country.

The *Mapping the Homelessness Workforce* survey, commissioned by MHCLG and published in 2026, surveyed staff across local authority and voluntary, community and faith sector organisations and provides the most comprehensive picture yet of the sector's workforce. The findings on learning and development are striking: while staff identified CPD-accredited training (51%), gaining qualifications (49%), mentoring (47%), and coaching (43%) as provision they were interested in but had not been offered, the most commonly available formats remained online e-learning and face-to-face compliance training.

4. Why the Inverse Training Law Persists

The inverse training law is not sustained by any single cause. It reflects an intersection of structural factors that, together, produce a systematic disinvestment in frontline workforce development.

The absence of professional regulation

Without a regulatory body setting minimum training standards, there is no floor below which provision cannot fall. Training investment in the homelessness workforce is discretionary, dependent on the priorities and resources of individual employers. In a sector characterised by tight commissioning margins, training budgets are among the most vulnerable to cuts. The absence of regulation removes the mechanism that, in nursing or social work, ensures basic standards are maintained regardless of financial pressure. MHCLG-funded workforce projects do not yet have a clear roadmap to professionalisation, although this may be something that will emerge in the next few years.

The undervaluation of relational work

There is a persistent cultural assumption that working effectively with excluded populations is primarily a matter of character, resilience, compassion, 'the right values.' Training is seen as supplementary to innate qualities rather than as the basis of skilled practice. This assumption simultaneously devalues the expertise of experienced frontline workers and reduces the perceived urgency of investing in their development. Training can support staff in enhancing their natural talent, particularly in establishing and maintaining relationships that are fundamental to change.

The invisibility of the workforce

The homelessness support workforce does not have a strong collective voice in policy and workforce debates. It is not represented by a powerful professional association. Existing workforce analyses such that mentioned above, or ‘A National Framework for NHS – Action on Inclusion Health published in 2023 have yet to bear significant fruit in terms of delivery for front-line staff. This invisibility means that its development needs are consistently overlooked in funding decisions and policy development and a coherent approach that results in a route to professional practice remains elusive.

5. The Cost of the Inverse Training Law

The costs of the inverse training law are borne in multiple places simultaneously.

They are borne by the workforce itself. Workers who receive inadequate support for the emotional and relational complexity of their roles are at significantly elevated risk of vicarious trauma, compassion fatigue, and moral injury, the particular form of distress that arises when workers are prevented by systemic constraints from acting in accordance with their values. Burnout and turnover rates in homelessness services are high, and the loss of experienced workers carries significant costs for services, for residents, and for the sector's institutional memory.

They are borne by the people those workers serve. Continuity of relationship is one of the most consistently identified factors in positive outcomes for people experiencing homelessness. When workers leave, as they do at high rates, relationships rupture, trust is lost, and recovery trajectories are disrupted. Under-supported workers, however committed, are less able to provide the kind of reflective, intra- and interpersonally aware engagement that research suggests is most effective.

And they are borne by the sector ecosystem as a whole. Investment in workforce development is not a cost to the homelessness sector but is a return on investment in outcomes. Services staffed by a skilled, stable, reflective workforce achieve better results for residents and clients, reduce the revolving door of crisis-driven service use, and contribute to the sustainable reduction of homelessness that national policy aspires to but rarely achieves.

6. A Response to the Inverse Training Law

Addressing the inverse training law requires more than a collection of additional training courses. It requires a systematic commitment to the principle that frontline workers in the homelessness and inclusion health sector deserve the same quality of professional development as their counterparts in other parts of the health and care system, sand that this commitment must be backed by resources, by recognition, and by the development of a coherent professional identity for the sector.

The Centre for Homelessness Research and Practice (CHRP) at the University of Southampton, in partnership with OutcomeHome CIC, is developing a tiered training and education offer designed to address the inverse training law directly. It is built on four principles:

- Accessibility: Training that begins where frontline workers are, not where a curriculum designer assumes they should be; delivered in formats that accommodate shift patterns, irregular working hours, and varying educational backgrounds. Pathways to qualification should be established, in collaboration with sector partners such as Homeless Link and the Chartered Institute of Housing.
- Appropriate certification: A professional qualification in this sector should start at Level 7, a postgraduate certificate. This puts it on the same footing as other practitioners and explicitly recognises existing experience.
- Recognition: Every element of the offer is formally accredited or certified, ensuring that the learning of frontline workers is given the professional recognition it deserves

The CHRP role within a collaboration is to provide the L7 University qualification – the Postgraduate Certificate in Psychological Practitioner in Homelessness. This programme is designed for workers who are moving toward a specialist practitioner role. The programme curriculum emphasises the skills that experts by experience and sector staff told us they need, including providing reflective consultation, leading on psychological approaches within services, and contributing to the development of psychologically informed cultures across the sector. Other programmes may support a pathway to qualification, with an accreditation organisation overseeing standards of education and practice. This structure sets up an end-to-end professional pathway for the sector, with different organisations across different government departments collaborating to deliver a suite of programmes that are inclusive, accessible and quality benchmarked.

7. A Call to Action

The inverse training law will not be addressed by the efforts of any single organisation. It requires a collective commitment from across the homelessness and inclusion health sector — from commissioners, from NHS partners, from local authorities, from housing associations, from the charitable and social enterprise providers who deliver the majority of frontline services.

That commitment involves several things:

- Recognising workforce development as a core component of service quality, not an optional extra. This requires appropriate resourcing and commissioning based on other models of professional accreditation.
- Investing in training budgets for frontline workers proportionate to the complexity of the work they undertake, not as a residual after other costs are met

- Supporting the development of a coherent professional identity and career pathway for inclusion health workers, including engagement with emerging frameworks such as those being developed across the sector
- Prioritising the lived experience of the workforce. The people who have themselves experienced homelessness and exclusion should be prioritised in informing and delivering curricula.

The inverse care law took decades to name, longer still to begin to address. But naming it mattered. It created a language for a structural injustice that had previously been invisible, and it generated the pressure for change. The inverse training law has been operating in the homelessness sector for as long as there has been a homelessness sector. It is time to name it and to catch up with our European neighbours, to act.

ABOUT THE AUTHOR

The Centre for Homelessness Research and Practice (CHRP) is based at the University of Southampton. It undertakes applied research, develops professional education, and engages in policy and practice development in the homelessness and inclusion health sector.

OutcomeHome CIC is a social enterprise delivering psychological services and workforce training to people experiencing homelessness and to the organisations that work with them.

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