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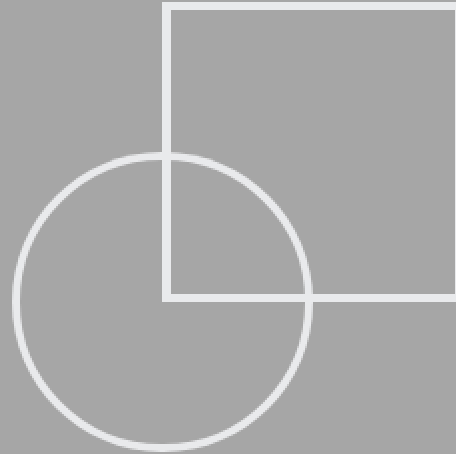

Law of 2 January 2002: a structuring reform of social and medico-social policies

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Law 2002-2: users' rights and medico-social framework: Strengthening of people's rights, contract with users, inclusion in the Code of Social Action and Families (CASF).

Introduction

Law No. 2002-2 of 2 January 2002 renewing social and medico-social action constitutes a major reform in the development of French public policies aimed at vulnerable groups. Far from being limited to a simple technical adjustment of the existing legal framework, it is part of a profound movement to transform the social and medico-social sector, which began in the 1970s. This reform marks the transition from an essentially protective and institutional logic to an approach focused on the rights, participation and autonomy of the people supported.

In a context marked by the rise of democratic requirements, the recognition of fundamental rights and the desire to improve the quality of public services, the 2002 law redefined the missions of the sector and strengthened the role of the user, who was now considered to be a full-fledged actor in his or her own way. It thus introduces new tools, new obligations for institutions and more precise and frequent evaluations aimed at guaranteeing the quality of support as well as the rights of users.

Therefore, in what way does the law of 2 January 2002 constitute a structuring reform of social and medico-social policies, and how does it transform professional practices as well as relations between institutions and users? To address this issue, it will first be necessary to analyse the context and foundations of this reform, before studying its main contributions, particularly in terms of users' rights, contractualization and quality of services.

1. A reform in a context of social and political change

Law No. 2002-2 of 2 January 2002 cannot be understood solely as a sectoral reform of child welfare. This reform is part of a much broader evolution of French social and medico-social policies. It is the result of a long process of transformation of the social sector. It is part of a profound recomposition of French social and medico-social policies that has been underway since the 1970s.

Before the 1970s, the distinction between health and social care was not yet clearly established. The care was not separate, and the hospital managed not only care, but also different reception structures for different groups, such as hospices, structures for the disabled or elderly, and even some children's homes. The law of 31 December 1970 marked an important first step, as it refocused the hospital on its main mission, i.e. care. It thus contributes to the gradual separation of the health field from the social field.

This evolution continues with the two laws of 30 June 1975. One concerns people with disabilities, the other social and medico-social institutions. Together, they are trying to better organize a sector that is still poorly structured. They make it possible both to put existing institutions in order and to better recognize the needs of certain vulnerable groups. They also reflect an initial desire to structure public intervention around specific groups, marking the beginning of a rationalisation of the social sector.

The 2002 law is therefore not a starting point, but rather the culmination of a reorganization that began several decades earlier.

In addition, at the end of the 1990s, the social and medico-social sector faced several criticisms: the opacity of institutions, the asymmetry of relations between professionals and users, and insufficient recognition of fundamental rights. Inherited from the 1975 law, the organisation of the sector is still largely based on a logic of protection, sometimes paternalistic, in which the person being supported has little to do with his or her own career.

In a broader context of transformation of public action, marked by the rise of democratic demands, the recognition of individual rights and the emergence of a logic of quality of public services, Law 2002-2 is part of a movement to modernize the welfare state. It also reflects the growing influence of the principles stemming from European public policies, particularly in terms of users' rights and the quality of services.

Thus, this law is not limited to a technical reform: it is part of a paradigm shift, moving from a logic of assistance to a logic of rights, participation and responsibility.

It does not seem that a single specific event or a single major social movement was at the origin of the 2002 law. Rather, the reform is based on an accumulation of observations. On the one hand, the framework put in place in 1975 seemed less and less adapted to the reality of the social and medico-social sector, which had developed and diversified considerably. On the other hand, expectations had changed: it was no longer enough to organise establishments, it was also necessary to better guarantee the rights of the people being supported. At the same time, several criticisms were aimed at the practical functioning of child protection, in particular the insufficient place given to families, the lack of coherence between certain types of care and the limits of the existing institutional framework.

On the political level, the reform was prepared over several years. The project was launched in 1996, then it was the subject of consultations with the sector's stakeholders. The bill was then tabled in the National Assembly on 26 July 2000. It is therefore a reform built gradually, in a context where the public authorities are seeking to adapt social and medico-social action to new institutional, social and legal realities. The unanimous adoption of the text at first reading shows that it was not so much a reaction to an immediate crisis as a profound reform, which was widely considered essential.

It is in this context that Law No. 2002-2 of 2 January 2002 comes into play. Its importance is major, because it redefines the foundations of social and medico-social action. It specifies the missions of the sector, strengthens the rights of users and affirms principles such as respect for dignity, individualisation of support, participation of the people concerned and a better assessment of needs. It thus marks the transition from a logic of organization of structures to a logic of regulation of practices.

Even if it does not only concern ESA, it profoundly modifies the framework in which it operates.

Indeed, the law of 2 January 2002 renewing social and medico-social action constitutes a major reform of French public policies in terms of care for vulnerable groups. It marks a break with previous logics by placing the user back at the heart of the system. The model is now focused on the rights, needs and voice of users. The law transforms professional practices, modes of governance and the legal framework of the sector.

Here are the two major articles of Law 2002-2:

- *Article 2: An Article L. 116-1 is inserted into the Code of Social Action and Families, worded as follows: "Art. L. 116-1. - Social and medico-social action aims to promote, within an interministerial framework, the autonomy and protection of individuals, social cohesion, the exercise of citizenship, to prevent exclusion and to correct its effects. It is based on a continuous assessment of the needs and expectations of members of all social groups, in particular persons with disabilities and the elderly, persons and families who are vulnerable, in precarious situations or in poverty, and on the provision of benefits in cash or in kind. It shall be implemented by the State, local authorities and their public establishments, social security bodies, associations and social and medico-social institutions within the meaning of Article L. 311-1. »*
- *Article 3: An Article L. 116-2 is inserted into the Code of Social Action and Families, which reads as follows: "Art. L. 116-2. - Social and medico-social action is carried out with respect for the equal dignity of all human beings with the aim of responding in an appropriate way to the needs of each of them and guaranteeing them equitable access throughout the territory. »*[1]

2. Inclusion in a structuring legal framework: the Code of Social Action and Families

One of the fundamental contributions of the law is its inclusion in the Code of Social Action and Families (CASF), which makes it possible to structure and unify the entire sector. This

[1] Légifrance. (2002, January 2). *Law No. 2002-2 of 2 January 2002 renewing social and medico-social action*. Official Journal of the French Republic. https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000215460/

codification reinforces the readability of the standards and imposes a common framework for all social and medico-social establishments and services (ESSMS).

From a public policy perspective, this reflects a desire on the part of the State to better regulate the sector, by clearly defining the missions, obligations and control procedures. For example, a nursing home can no longer operate according to its own informal rules: it must comply with a set of precise legal requirements regarding residents' rights, mandatory documents and assessment procedures.

This harmonisation contributes to the construction of a genuine public social and medico-social service, even when the structures are managed by associative or private actors.

3. Strengthening users' rights: a strong social citizenship

The heart of the reform lies in the explicit recognition of the rights of users, who are now considered to be subjects of law in their own right. The law enshrines fundamental principles such as respect for dignity, integrity, privacy, free choice, confidentiality and access to information.

In a public policy reading, this evolution reflects the emergence of a social citizenship, where vulnerable people are no longer only protected, but also recognized as actors capable of expressing choices and preferences.

There are 7 mandatory tools in ESSMS establishments (Social and medical social establishments and services) that guarantee the rights and freedoms of people who welcome:

1. The welcome booklet
Document given to the person welcomed at his entrance. It presents the establishment, its services, its operation and the rights of users.

2. The Charter of Rights and Freedoms of the Person Welcomed
It recalls fundamental rights (dignity, respect, confidentiality, free choice, etc.). It stems from the Charter of Rights and Freedoms of the person being cared for.

3. The residence contract or individual document of care (DIPC)
Written agreement between the user and the establishment that specifies:

- The services offered
- The objectives of the support
- the terms of stay

4. Operating regulations
It defines the rules of collective life:

- Daily organization
- Rights and duties
- Safety rules

5. The establishment or service project
Strategy document that describes:

- Values and missions
- Objectives
- the means implemented

6. The Social Life Council (CVS)
A body for the participation of users and their representatives. It allows you to give an opinion on the functioning of the establishment.

7. The Personalized Project
Document focused on the person being accompanied:

- its needs
- His expectations
- Its objectives
- The actions implemented

This evolution is also part of a logic of prevention of institutional mistreatment, by imposing obligations of vigilance and promoting well-treatment.

4. Contractualization: towards a balanced service relationship

The law introduces a major transformation of the relationship between institutions and users through contractualization. The residence contract or the individual document of care formalises the reciprocal commitments and specifies the services offered. In addition, these measures modify professional practices

This mechanism reflects a shift in public policies towards a logic of service rendered, inspired by public management. The user becomes a sort of "co-contractor" of his or her care.

For example, in nursing homes, the contract specifies the conditions of accommodation, the services offered and the rates, thus offering increased transparency for the person and his

or her family. In a home care service, an elderly person can refuse certain hours or ask for a change of caregiver, which is a concrete illustration of the principle of free choice.

Another example, a child in care is now informed of the reasons for his or her care and participates in his or her educational project, which breaks with previous practices where decisions could be imposed without explanation. The Personalised Plan is drawn up within the childcare facility with the child's child welfare representative, the childcare centre's referent and, of course, the child's parents, except in the event of deprivation of parental authority.

However, this contractualization also raises questions: to what extent is a vulnerable person or in the context of this memo, a child really able to "defend" his or her project in the face of failing adults or parents? How is the child's voice guaranteed in institutions according to his age, his skills and his desires.

In addition, to what extent the parent and the child feel legitimate in contradicting a public institution and, above all**, how their rights and duties are explained to them.**

5. Tools for participation and health and social democracy

The law puts in place several mechanisms aimed at guaranteeing the effectiveness of rights, in particular the Social Life Council (CVS), the operating regulations and the establishment project.

The CVS is a participatory body allowing users and their families to express themselves on the life of the establishment. Each CVS decides on the number of people to be elected, but it includes at least:

- 3 representatives of the persons welcomed or accompanied, or their legal representatives or their families;
- 1 staff representative;
- 1 representative of the managing body

In some nursing homes, this body has a real impact: residents can, for example, ask for an improvement in meals or activities, and obtain concrete changes. CVS are also set up in establishments for minors. An example of youth participation through the CVS is described in a study conducted in a[2] child protection facility for adolescents (MECS).[3] In this structure, the Social Life Council was used as a **tool for learning citizenship and speaking.**

The young people regularly participated in the meetings, where they could express their opinions on daily life (collective rules, organization, relations with professionals). The CVS also allowed them to structure their speech by getting them to debate, argue and represent other young people. This participation contributed to their empowerment and involvement in their educational journey.

However, the study stresses that this participation requires **significant educational support**: professionals must help young people to understand the role of the CVS, to formulate their ideas and to appropriate this space for expression. Without this support, participation may remain limited or symbolic.

From a public policy perspective, these measures reflect a desire to develop a form of participatory democracy in the social and medico-social sector. They are an extension of health democracy policies, aimed at involving users in decisions that concern them.

In addition, their effectiveness depends heavily on the conditions of implementation. In some cases, participation remains symbolic, especially when the people supported are very vulnerable (cognitive disorders, severe disability).

6. Introducing a culture of evaluation and quality

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[2] Noël, M. (2008). *The participation of young people in the social life council of a child protection establishment*. **Social Life**, 2(2), 55–63. https://doi.org/10.3917/vsoc.082.0055

[3] Children's Home with a Social Character

Another major contribution of the law is the introduction of internal and external evaluation of schools. This requirement is part of a logic of steering public policies through performance and quality.

Internal evaluation allows teams to reflect on their practices and identify areas for improvement. For example, a structure can analyze an increase in falls among residents and implement prevention measures.

The external evaluation, carried out by an independent body, provides an objective view and conditions the renewal of authorisations. It strengthens the accountability of managers and transparency vis-à-vis public authorities.

This dynamic contributes to the professionalization of the sector, but it can also generate a significant administrative burden for the teams, sometimes to the detriment of the time devoted to direct support.

Moreover, this evaluation dynamic has recently been reinforced and clarified by the regulatory framework, in particular with Decree No. 2022-695 of April 26, 2022, which amends Decree No. 2021-1476 of November 12, 2021[4] on the pace of quality evaluations of social and medico-social establishments and services (ESSMS).

This text marks an important evolution by introducing a more structured, harmonized evaluation system refocused on the quality of user support. From now on, external evaluations are carried out at a defined interval, with a regulated rhythm over the duration of the authorisation (generally every five years), and according to a single national reference framework drawn up by the Haute Autorité de Santé (HAS). This standardisation aims to ensure better comparability of results between institutions and to improve readability for supervisory authorities.

The 2022 decree also makes technical adjustments, in particular by specifying the transitional arrangements and adapting the implementation schedule for structures already authorised. It thus responds to the operational difficulties encountered when the previous system came into force, by offering more flexibility to managers while maintaining a high level of requirements.

In addition, this new framework insists on an approach centred on the person being supported: the evaluation no longer focuses only on procedures or organisation, but also on the effectiveness of users' rights, the personalisation of support and the quality of life within the establishments. This reflects a paradigm shift, moving from a logic of administrative compliance to a real culture of quality.

However, while these developments contribute to strengthening the coherence and credibility of the evaluation system, they also imply an increase in the skills of the teams and an increased mobilization of internal resources. The preparation of evaluations, the collection of indicators and the appropriation of the HAS reference framework can represent a significant workload. Thus, the challenge for the establishments remains to reconcile these increased requirements with the maintenance of human and individualised support for the people welcomed.

7. A recomposition of social public action

The law of 2 January 2002 contributes to a comprehensive reorganisation of the social and medico-social sector, in particular through the strengthening of the mechanisms for authorisation, planning and regulation of supply. Establishments and services must now be part of departmental or regional plans, built on the basis of an analysis of the needs of the territories.

In the field of child protection, this evolution is reflected in a better adaptation of the childcare offer to local realities. For example, in a department facing an increase in the number

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[4] Prime Minister. (2022). Decree No. 2022-695 of 26 April 2022 amending Decree No. 2021-1476 of 12 November 2021 on the pace of quality assessments of social and medico-social establishments and services. Official Journal of the French Republic. https://www.legifrance.gouv.fr/loda/id/JORFTEXT000045668643/

of unaccompanied minors (UAMs), the authorities may decide to create or open specific mechanisms, such as emergency reception structures or support mechanisms towards autonomy. Similarly, in the face of an increase in the placement of adolescents with behavioural disorders, specialised educational units or places in adapted MECS can be developed. Thus, planning no longer aims only to organise what already exists, but to anticipate and respond in a targeted manner to changes in the public welcomed.

This logic reflects a transformation of public action, which is now more strategic and territorialized. It is based on a detailed identification of needs, making it possible to avoid mismatches between the proposed measures and the situations encountered. For example, a lack of foster families in certain territories may lead to the strengthening of recruitment and training policies for family assistants, in order to favour more individualised care methods.

In addition, the law strongly encourages coordination between the various actors involved in the child's journey, in order to limit breakdowns in care, which are particularly frequent in child protection. In concrete terms, a child in care can be accompanied in a coordinated manner by a variety of professionals: educators specialising in MECS[5], social workers from the Child Welfare Agency (ASE), psychologists, teachers and sometimes child psychiatry services. This coordination takes the form of summary meetings, shared personalised projects and supervised exchanges of information.

For example, when a child experiences successive changes of place of placement (foster family, home, return to the family), enhanced coordination between the services ensures continuity in educational and psychological support. It aims to avoid breaks in the pathway, which are often detrimental to the child's development, by guaranteeing coherence in educational interventions and objectives.

Thus, the Act of 2 January 2002 contributes to a recomposition of public action in child protection, by promoting an approach that is both more planned, more coordinated and more focused on the specific needs of children and families. However, the effectiveness of these principles remains dependent on the resources mobilized, the dynamics of local partnerships and the ability of the actors to work together in a logic of continuity of pathways.

Conclusion

The law of 2 January 2002 constitutes a major turning point in French social and medico-social policies. It enshrines an approach based on rights, participation and quality, and profoundly transforms the relationship between institutions and users.

Beyond its legal provisions, it embodies a broader evolution of the welfare state towards a more democratic, transparent and person-centred model. However, its effectiveness is based on concrete conditions of implementation, which remain a central issue for contemporary public policies.

Despite its progress, the law has certain limitations. Its implementation is uneven depending on the institution, and the risk of formalism is real. The proliferation of documents (contracts, projects, evaluations) can sometimes distance professionals from human relations.

In addition, user participation is sometimes limited, especially for the most vulnerable groups. For example, a person with cognitive impairment may have difficulty understanding their rights or actively participating in decisions.

These limitations show that the success of the reform largely depends on its appropriation by the actors in the field and on the ability of public policies to support this change (training, resources, supervision).

This is why the controls and evaluations of establishments have been strengthened thanks to Decree No. 2022-695 of April 26, 2022, which amends Decree No. 2021-1476 of November 12, 2021.

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[5] Children's Home with a Social Character

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