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Introduction

Since the 1970s, numerous reports have studied child protection in France. Their themes have evolved: the first studies focus mainly on placement, prevention and the place of families; more recent reports place more emphasis on organization, understanding of pathways, children's voices and violence.

This work has accompanied the reforms of the sector, but has also highlighted the persistence of difficulties already identified: late interventions, breaks in the pathway, insufficient coordination between services and strong territorial differences. The reappearance of these findings from one report to the next therefore raises the question less of the absence of recommendations than of their implementation and their ability to produce concrete changes.[1]

This memo examines the main national reports in order to identify what they have changed in the way of thinking about child protection, the findings on which they converge and the difficulties that remain. The challenge is to understand why certain long-standing concerns remain central even though the legal and institutional framework has changed profoundly.[2]

I. Dupont-Fauville and Bianco-Lamy: strengthening prevention and support for families

From the 1970s onwards, the Dupont-Fauville and then Bianco-Lamy reports helped to call into question an organisation that was still largely focused on placement. They gave more importance to prevention and work with families, while raising the question of the continuity of support.[3]

Submitted in 1972 and published in 1973, the Dupont-Fauville report proposes to shift the centre of gravity of child welfare to earlier intervention. It emphasizes prevention in the living environment, continuity of follow-up and less compartmentalized action between the social, educational and health dimensions. The report also defends teamwork within the sector and support for families when the safety of the child makes it possible to avoid separation. According to the report, the quality of follow-up also depends on the ability of professionals to intervene in a coordinated and long-term manner.[4]

In 1980, the Bianco-Lamy report deepened this orientation by giving a more important place to the child and his family. It defended the development of interventions in an open environment, i.e. measures to support the child and his family without systematically resorting to placement. It also insisted on the need to better inform parents of the decisions taken in their regard and to preserve, when this did not compromise the child's safety, family ties that could continue to play a role in his

[1] Court of Auditors (2020), Child protection: a policy unsuited to the child's time, summary and appendix 2; National Assembly (2025), Report on the shortcomings of public policies for child protection, volume I.

[2] Court of Auditors (2020), Child protection: a policy unsuited to the child's time, introduction; National Assembly (2025), Report on the shortcomings of public child protection policies, volume I.

[3] Dupont-Fauville (1973), Pour une réforme de l'aide sociale à l'enfance; Bianco and Lamy (1980), L'aide à l'enfance demain; Verdier (2012), "La mise en question du placement", Journal du droit des jeunes, n° 311, p. 44–47.

[4] Dupont-Fauville (1973), Pour une réforme de l'aide sociale à l'enfance; Verdier (2012), "La mise en question du placement", pp. 44–47; Assemblée nationale (2025), report n° 1200, volume I.

or her career. It also proposed a unified service for children at the departmental level, bringing together ASE, maternal and child protection, social services, school health and child psychiatry.[5]

These two reports reveal a tension that remains central to child protection: supporting the family and avoiding separations when they can be separated, while ensuring that maintaining family ties does not delay a protection measure that has become necessary for the child. They also show very early on that more individualized protection presupposes an organization of services capable of ensuring the continuity of the pathway.[6]

II. Governance, pathway knowledge and service coordination

From the 2000s onwards, reports were less interested in the principles of care than in the conditions of their application. The responsibilities between the State and the departments, the quality of the information available and the ability of institutions to act together became central subjects.[7]

The Court of Auditors particularly highlights the gap between the adoption of a reform and its implementation. In its 2020 report, it notes that several recommendations made in 2009 have been included in national texts or strategies without being fully implemented. In particular, it calls for clarification of management, strengthening controls and developing studies on the future of protected children. The challenge is concrete: a legal obligation does not produce the same effects depending on whether responsibilities are clearly assigned, resources have been provided for and its application can be monitored over time.[8]

The work of the ONPE highlights an important limitation: the available data make it possible to know quite precisely the number of measures taken by the ASE, but much less easily to monitor what children experience during their care. The Observatory therefore seeks to better document their pathways, particularly in terms of health, schooling or transition to adulthood. It is no longer just a question of knowing how many children are supported, but of being able to identify the ruptures they experience: changes in place of care, interruption of care, academic difficulties or conditions of discharge from ASE. However, this information remains difficult to collect and compare in a homogeneous way between territories.[9]

Finally, the General Inspectorates show what these difficulties produce in concrete situations. Their work on prevention and on violent deaths of children within families underlines that several services may each have some of the information without a common assessment of the danger being built up in time. Coordination therefore does not consist only of multiplying exchanges: it presupposes that the relevant information can be reconciled, that an actor is able to draw a decision from it and that a relay exists when the situation exceeds the competences of a single service.[10]

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[5] Bianco and Lamy (1980), Child Aid Tomorrow; Dini and Meunier (2014), Child Protection: Improving the System in the Interest of the Child, Senate, Report No. 655, pp. 76–77; National Assembly (2025), Report No. 1200, Volume I.

[6] Comparative analysis based on Dupont-Fauville (1973), For a reform of child welfare; Bianco and Lamy (1980), Child welfare tomorrow; IGAS, IGAENR and IGEN (2019), Evaluation of the prevention policy in child protection; Court of Auditors (2020).

[7] Dini and Meunier (2014), Child Protection; Court of Auditors (2009), Child Protection; Court of Auditors (2020), Child Protection: A Policy Unsuited to the Time of the Child.

[8] Court of Auditors (2020), Child protection: a policy unsuited to the child's time, summary, p. 11, and appendix 2.

[9] ONPE (2020), Knowledge for acting in child protection; ONPE (2022a), The health of protected children; ONPE (2022b), The schooling of protected children; ONED (2015), Support towards autonomy for "young adults"; Court of Auditors (2020), Child protection.

[10] IGAS, IGAENR and IGEN (2019), Evaluation of the prevention policy in child protection; IGAS, IGJ and IGAENR (2018, publication 2019), Mission on violent deaths of children within families.

Taken together, these reports show that child protection depends not only on the quality of the decisions taken, but also on the way in which they are applied and relayed between institutions. Information that is not transmitted, a measure that is slow to be implemented or an ill-defined responsibility can create a break in the child's pathway. The continuity of care is therefore also based on the ability of services to share information, coordinate and relay from one intervention to another.[11]

III. The CIIVISE and the 2025 Commission of Inquiry: better acknowledging violence and strengthening public accountability

Recent reports shed more light on the situations in which the institutions themselves fail to protect. The CIIVISE analyses the obstacles encountered by victims of sexual violence to be heard and accompanied; the 2025 parliamentary commission of inquiry extends this diagnosis to the general organisation of child protection.[12]

In its 2023 report, the CIIVISE makes 82 recommendations based on listening to victims and analysing institutional responses. They concern the identification of violence, its judicial treatment, reparation and prevention. The report insists above all on the effects of denial and doubting one's word: collecting a story only has a protective impact if it quickly leads to an assessment of the situation, security measures and effective access to care and justice.[13]

The report of the National Assembly's commission of inquiry, tabled on 1 April 2025, makes 92 recommendations. In particular, it proposes an interministerial strategy, multi-year funding and a common information system. It also calls for representatives of children in care and former children in care to participate in departmental committees for child protection, so that their experience contributes to the governance of the system.[14]

These two reports work on different scales, but they set the same requirement: recognizing a right or violence is not enough if no organization is able to translate this recognition into effective protection.[15] The question of public responsibility then becomes central, whether it is a question of the response given to a revelation of violence or of the general capacity of the system to carry out the measures decided.

IV. Recurring recommendations: what their persistence reveals

[11] Court of Auditors (2020), Child Protection, chap. III; IGAS, IGAENR and IGEN (2019), Evaluation of the prevention policy; IGAS, IGJ and IGAENR (2018), Mission on violent deaths of children within families.

[12] CIIVISE (2023b), Sexual violence against children: "We believe you"; National Assembly (2025), Report on the shortcomings of public policies for child protection, volume I.

[13] CIIVISE (2023a), Summary of the report "Sexual violence against children: we believe you", p. 23–27.

[14] National Assembly (2025), Report on the shortcomings of public policies for the protection of children, Volume I, recommendations Nos. 5, 7, 13–15 and 19.

[15] CIIVISE (2023b), Sexual violence against children: "We believe you"; National Assembly (2025), Report on the shortcomings of public policies for child protection, volume I.

A comparison of the reports shows first of all a strong continuity. Prevention, stability of pathways and coordination between services have been apparent for several decades. Recent work adds more clearly to this the participation of children and the attention paid to the effectiveness of rights. This permanence does not mean that the reforms have changed nothing. Above all, it shows that certain difficulties persist when the principles adopted do not find the necessary conditions for their application.[16]

It is precisely this shift from recommendations to practices that recent reports insist on. In 2020, the Court of Auditors noted that nearly three-quarters of its 2009 recommendations had not been implemented or had only been implemented very partially. A recommendation can therefore be included in a law or a strategy without changing practices everywhere. The coordination difficulties described by the Defender of Rights in 2025 illustrate the same problem: when a situation relates to care, disability and child protection at the same time, the sharing of information is not enough if no service has the means or a sufficiently clear responsibility to provide care.[17]

Prevention is a good illustration of this difficulty. While Dupont-Fauville already made it a central orientation, the general inspectorates show that services under constraint concentrate their resources on the most serious situations. The more emergencies mobilise professionals, the less time and resources they have to intervene upstream. In 2025, the Defender of Rights again highlights the inequalities in the deployment of specialised prevention and the fragility of its funding, as well as the tensions affecting the PMI and home interventions. Prevention also requires taking into account the material conditions of families: the 2025 commission of inquiry calls for better documentation of the links between poverty and placement, in order to distinguish between the danger requiring a protective measure and the difficulties that could be mitigated by earlier support for housing, health or resources. The challenge is therefore not to reaffirm an old principle, but to preserve the means that make it possible to apply it.[18]

Finally, the reports suggest a better distinction between activity and results. Administrative data indicate how many measures are taken or how many places are occupied; they provide less direct information on what the care has enabled over time. Longitudinal studies, such as ELAP or the ONPE's cohort work, seek to follow the trajectory of young people beyond an isolated measure. This approach is essential to assess not only whether an intervention has taken place, but whether it has contributed to the child's security, the stability of his or her career and his or her effective access to rights.[19]

If the same difficulties reappear from one report to the next, the question is not only about the reforms decided, but also about the possibility for professionals to take the time to review situations, to change their practices and to respond to the tensions identified. Where can professionals have time to collectively reflect on situations and their own practices? These spaces exist, but they remain unevenly established. A survey by the French National Authority for Health of child protection

[16] Comparative analysis based on Court of Auditors (2020), Child protection; CIIVISE (2023b), "We believe you"; EESC (2024), Child protection is in danger; National Assembly (2025), Report No. 1200, Volume I.

[17] Court of Auditors (2020), Child Protection, Summary, p. 10, and Annex 2; Defender of Rights (2025), Framework Decision No. 2025-005, § 204–209.

[18] Dupont-Fauville (1973), For a reform of child welfare; IGAS, IGAENR and IGEN (2019), Evaluation of the prevention policy; Defender of Rights (2025), Framework Decision No. 2025-005, passages on the PMI and specialized prevention; National Assembly (2025), Report No. 1200, Volume I, Recommendation No. 20.

[19] INED (n.d.), Longitudinal study on the empowerment of young people after a placement (ELAP), presentation of the study; ONPE (2023), The pathways of protected children, Note Figures and analysis; ONPE (2022a), The health of protected children.

establishments presented the analysis of practice as a "resource place" for teams; 67% of responding establishments said they used it at least once a month with an external speaker. In 2025, however, the Defender of Rights notes that supervision or analysis of practices is still far from systematic in the departments and the authorised voluntary sector. When they exist, professionals sometimes explain that they are unable to participate because of daily emergencies. It recommends that social workers and local managers be able to access groups led by an external professional and to formalized feedback. Without these collective times, teams have fewer opportunities to understand why a situation has deteriorated and to make lasting changes to their organization.[20]

This difficulty also helps to understand why some reports seem to have little effect despite the repetition of alerts. In 2024, the EESC describes child protection as a "textbook case of the ineffectiveness of social policies". Two years later, the Senate notes that, despite a dense legislative framework, the conditions of care continue to deteriorate; it notes that more than 71% of establishments are experiencing recruitment difficulties, with nearly 30,000 vacancies. These figures alone do not explain the failure of a reform, but they show concretely what can prevent a recommendation from becoming a practice: structures, staff and decision-making circuits do not always evolve at the same pace as the texts. Continuing education is regularly reinforced or recommended, but it cannot compensate on its own for unstable teams or a workload that leaves little time to learn new practices.[21]

Conclusion

The major national reports show a real evolution in child protection, but also the persistence of several concerns. Dupont-Fauville and Bianco-Lamy already insisted on prevention, support for families and continuity of support. More recent work has highlighted the difficulties of governance and coordination, the breaks in the pathway, the violence suffered and the still insufficient space given to children's voices. The reforms have changed the legal framework and the tools available, without eliminating all these problems.

After several decades of reports, the main obstacle no longer seems to be the identification of difficulties. Institutions have many diagnoses and recommendations that are often convergent. The question now is how to follow up on them: what responsibilities are assigned, what resources support decisions and how can we verify that practices are really changing? A measure announced, a mechanism created or an obligation enshrined in law are not enough to demonstrate an improvement in children's careers. To assess the effect of reforms, it is necessary to be able to observe their application, the continuity of support and the results obtained over time. It is on this condition that the reports can be used not only to note the same difficulties, but also to measure what has actually changed for children in care.

Report	Main Finding	What it brings
Dupont-Fauville (1973)	This protection is still focused on placement, with interventions that are too compartmentalized.	Prioritizes prevention in the living environment, support for families and coordinated follow-up over time.

[20] Defender of Rights (2025), Framework Decision No. 2025-005, § 101 and Recommendation on the Analysis of Practices; Haute Autorité de Santé (2018), 2016 Survey Report on Professional Practices Contributing to Well-Treatment, p. 100.

[21] EESC (2024), Child protection is in danger: the EESC's recommendations; Senate (2026), Childhood in danger: solutions exist, it is time to take them up, report n° 574.

Bianco–Lamy (1980)	Parents need to be better informed and involved in decisions about their child.	Proposes to develop support for children and their families without systematically resorting to placement, and to create a unified departmental service for children to better coordinate interventions.
Court of Auditors (2009 and 2020)	In 2020, nearly three-quarters of the 2009 recommendations remain unimplemented or very partially implemented.	Calls for clearer management, reinforced controls and more studies on the future of protected children.
General Inspections (2018–2019)	Some services may each have part of the information without a joint assessment of the danger being made in time.	Stress the need to bring information closer together, coordinate interventions and better prevent serious situations.
ONPE and ONED (2015–2023)	The number of measures is better known than the children's pathways, in particular the break-ups and the conditions of exit from the ASE.	Document health, schooling, access to autonomy and long-term trajectories.
CIIVISE (2023)	Denial and doubting of victims' words can hinder their protection.	Makes 82 recommendations on the identification of violence, justice, reparation and prevention.
EESC (2024)	Child protection is described as a "textbook case of the ineffectiveness of social policies".	Highlights the gap between the policies announced and their concrete implementation.
Defender of Rights (2025)	Coordination between protection, care and disability remains fragile; prevention and supervision times are unevenly ensured.	Highlights the gap between the policies announced and their concrete implementation.
National Assembly (2025)	The shortcomings concern in particular governance and the place given to the experience of protected children.	Makes 92 recommendations, including an inter-ministerial strategy, multi-year funding, and youth engagement.
Senate (2026)	More than 71% of establishments are experiencing recruitment difficulties and nearly 30,000 positions are vacant.	Shows the limits of a dense legislative framework when staffing levels and conditions of care remain degraded.

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