[Stuart Malcher] Morning, everyone. Thanks for joining. Apologies, we were a couple of minutes late jumping online, but we've gone three minutes past, so we'll make a start, and we might have a few colleagues joining us as we continue. So yeah, my name's Stuart Malcher. I'm sitting in the chair for FACSIAR. Jessica Stewart's back from maternity leave, but grateful for the opportunity to job share with her two days a week. Can I welcome, joining us for our POCLS roundtable, we've obviously got members of the POCLS Advisory Group, who we've just met with prior to this, but also now, we're being joined by the Evidence to Action Working Group and the Study Working Group, and also our academics who'll be presenting today. Can I start this meeting by acknowledging that we're all living and working on Aboriginal land. We're in Parramatta today, which is the land of the Dharug people, and I pay my sincere respects to all First Nations elders past, present, and to emerging and future leaders, and I extend that respect to Aboriginal colleagues joining us on the line, and as always, our Aboriginal colleagues working across the great state of New South Wales in an incredibly important industry. So, look, excited to say, this is our fifth POCLS Roundtable for the year. We had four in, I think it was February, in succession, which I know, personally, I found incredibly interesting. I think it's always a pleasure to get to hear the latest research and evidence, and it's a pretty thought-provoking way to spend the day, and presenting insights from fifteen commissioned Academic Researchers, and from also from the POCLS team. So the benefit of these Roundtables is that it brings together the latest research, colleagues from academic fields, as well as policy and operational experts to really chew over what can we do to improve services and outcomes for vulnerable children and families? Our problem statement that we're focusing on today for the Roundtable is around permanency planning for children and young people in out-of-home care, which is clearly a major goal for the child protection system. How do we improve decision-making and culturally appropriate support to children, carers, and families to ensure children attain permanency? And look, I won't lie, it's not all about me, but for my own vested interest, over the last four weeks, I've picked up responsibility for one of our Premier's Priorities, and increasing children exiting out-of-home care to permanency. So after this meeting, I have to go away and try and wrestle a project plan to some kind of coherence. So I'm really hoping that this discussion is going to make my life a whole lot easier doing that. So with that, I guess the question that we are really wanting to unpack, I'll introduce our three presenters in a moment, and then we'll have the benefit of hearing from them as they share the insights from their research. But the question is what are the implications that we want to be asking for policy, for practice, for programs, for data collection, and to agree on some areas where we can improve policy and practice? So as always, we're looking, as we just discussed in the previous meeting, we're really trying to draw that connection between the research and the findings that flow from it and where we can demonstrate or use that to inform decision-making to improve services. That's the mission, and also, the other question that we're open to, which is what we were just discussing with the advisory group, is any priority policy questions. So from today's presentations and discussion, if that opens the door to further questions that we want to then prioritise, we're also interested in that. So they're our two challenges for this morning. With that, can I flag that with the papers. There was a summary paper sent out from the management team, which gives a summary of the key findings from the three bits of research that we're about to hear in more detail, but if you haven't had a chance to read it, you'll have the opportunity to hear from the researchers themselves. So can I introduce them, and then we'll sort of hand over to the most important part of this morning. So we've got online, Dr. Fred Wulczyn, who is a Senior Research Fellow at Chapin Hall at the University of Chicago, and the Director of the Centre for State Child Welfare Data, and the work of the Data Centre is organised around research, evidence, public and private child welfare agency's need to improve outcomes for children. A core asset of the Data Centre is the multi-state foster care data archive with records of more than 4.5 million foster children and more than three decades of history. The archive is the oldest continuously updated data source of its kind in the world, and so, after we hear from Fred, we'll be turning to Dr. Catherine Wade, who is the Principal Research Specialist at the Parenting Research Centre. She leads research evaluation analysis activities at the Centre with a focus on evaluating the implementation and impact of initiatives aimed and improving the lives of vulnerable families across Australia and internationally, and Dr. Wade is also a Research Affiliate with the Research of Health Sciences at the University of Sydney, and finally, last but not least, we welcome to hear from Dr. Anne-Marie Laslett, who is a Senior Research Fellow, who directs a range and magnitude of alcohol's harm to other projects at the Centre for Alcohol Policy Research at La Trobe University in Melbourne, and for twenty years, she has undertaken alcohol and other drug research, focusing on alcohol's harm to children, families, communities in Australia, and cross nationally. So having introduced our three presenters, I'll hand over to Fred, and then, obviously, we'll follow in turn, and if you can take any questions, we'll have, obviously, discussion at the end of the three presentations. Over to you, Fred. Thank you very much.

[Fred Wulczyn] - All right, thank you very much. Good morning, good evening, depending upon what part of the world you're in. I re-read the instructions and it very clearly says that we're not to use slides, that this is an oral presentation, and it feels a bit like the recurring dream where you find yourself in front of a group of people only partly clothed to have a presentation without any slides. So bear with me while I try to manage the likelihood of embarrassment here. So I'm here to talk about infants and toddlers leaving out-of-home care. I want to circle back to the conversation we had earlier today in the last hour, and then amplify something that was mentioned just a moment ago, and that is the emphasis on permanency planning, and I'll do that by making some simple comparisons with what we know about what's true in the U.S. and what I believe to be true in New South Wales, if not, all of Australia, but let me just start by pointing out, perhaps it's the obvious, but why study infants and toddlers? It's because they're the largest, most significant group of children entering in out-of-home care. Regardless of, sort of, the way in which you measure it, from all indications that we have and from what we know from the POCLS study is that if we look at the problem from a dose response perspective, so foster care, out-of-home care is thought to have a causal influence on the wellbeing of children, and so, to the extent that that's true, it really matters, how much do you get? How much exposure do you have to that causal influence? And the reality is that infants have a larger dose of out-of-home care than, virtually, any other group of children by virtue of the fact that they start out very young, and the possibility of exposure is much greater from birth till age 18. It's very different if you enter out-of-home care for the first time as a five-year-old, as a 10-year-old. The amount of exposure you've had to early life experiences in the home of your parents or with other members of the family is dramatically different. So this group of kids and the exposure they get to foster care is extremely important from the perspective of understanding, well, what is the meaning of foster care for these very young kids? In other conversations about this particular work, I try to encourage people to think, to broaden our use of the term care leavers. These are young people who leave care. Leaving care is not something that's reserved for 18-year-olds making the transition to adulthood. That's a very particular type of, or very particular subset of the population who is leaving care. But every group of children who leaves care faces developmental challenges, whether they're leaving care at age 18 for the transition to adulthood, or they're leaving care at the age of four, or five, or six, making the transition into their primary school grades. These are important transitions. Foster care prepares the quality of care, helps prepare young people for those transitions, and I think thinking about the transition to life after foster care as care leavers, how do we prepare for them, and then how do we support them once they've made that transition is an important aspect of this. The most recent data that I've seen from New South Wales suggests that this is in fact like in the US, like the UK, like other parts of the world. This is a very important sub-population in terms of just the numbers of kids. When you multiply that by the length of time they spend an out-of-home care, no other group has an impact on the out-of-home care system like the very young babies. You've seen the summary, so I don't want to go into depth and repeat what you've had a chance to read or could read later on. I will simply point out that- and this is the comparative aspect of what we're doing, and it gets to the question of permanency planning and what can we do? According to the latest information, and Marina and colleagues, if I misinterpreted what you said, by all means, correct me, but they passed on to me information about the whereabouts of the zero to three-year-olds in the original wave one interviews that we looked at when we studied restoration, and my read of that data suggests that 12 years on or 10 years on, I don't know exactly how long after the original entry into the study sample these most recent data are looking at, but somewhere on the order of 50% of those children were still in out-of-home-care ten years on. In the United States, by way of comparison, not to suggest that we have a virtuous child protection system, but almost none of those children would still be in out-of-home care. They would all be gone. Adopted, reunified, placed with relatives, but almost none of those children would be at home, and there will be some, but they are very unique subset of this very unique subset, likely with severe developmental disabilities, where the need for long-term care and the possibility of finding suitable family arrangements is diminished considerably. When we look at the possibility that a child will grow up in foster care, and I think that that's perhaps a realistic possibility for the roughly 50% of this cohort that is still in care. In the U.S. we're looking at one tenth of 1% of kids that will spend what's left of their childhood in out-of-home care, given that they entered out-of-home care in the first year of life. The sample here is a little bit larger, but I want to give you some sense as to why this question of the importance of out-of-home care and permanency planning, and can we facilitate the discharge of these kids to something other than publicly financed out-of-home care? I think it's one of the great moral questions that Western industrial societies face. What POCLS allows us to do is to answer the question, well, who are these children who spend so much of their early childhood in out-of-home care? And if we as a society, if you as Australians are interested in restoring children to their families, finding relatives, finding adoptive families, what will it take to be successful? Cause we now know something about who those children are, what the quality of care meant to them in terms of their life course opportunities, their life course chances, and then, in the pursuit of restoration, in the pursuit of adoption, in the pursuit of kin care arrangements outside of foster care, what will be required of us in order to make those decisions the right decisions? To make any of these decisions, whether they stay in care till they grow up in foster care, that's a decision we make. Do we restore them? That's a decision we make. Do we adopt them? That's a decision we make. There's nothing preordained about this. These are things we do, things we decide. We want to decide, how do we support them? How do we make these good decisions? And that is really the value, I think, of the POCLS data set and the study. How do we make these good decisions? Well, we have to know something about the children and the life they've lived and the life they need to live in order to be successful going forward. So when you look at the brief summary or go back to the study, when you look at all the studies that have been done with the POCLS data, we're essentially asking the question, what do we need to be successful to contribute to the success of these young people? This is a particularly important group because so much of their early life experience has been managed by and with the oversight of the public interest, the compelling interest of the government to care for these children. What is the effect of that? What is the benefit of that? And then, how do we make those decisions better? So when you read the report on the infants and toddlers, and the restoration, and the things that matter, case work matters, family matters, all of the things you would imagine are important in one way or the other. Aboriginal status makes a difference. Sometimes the differences are surprising because of the strengths of Aboriginal families. But this is looking forward, what does it say about how we do better by these young people? If the answer to the question is 50% of these young people being still in care, are we satisfied with that decision or would we make another decision, and what would that decision be? So I think that's the very important question that, Stuart, that you're asking about in terms of permanency planning. You're asking, is it time to make another decision for these children? And I think it may well be. It's a deep and important, I think, moral question about the role of the state and the lives of these children, and how do we do better? So let me stop there and pass it along to the next speaker.

[Stuart Malcher] Thank you, Fred. I'm furiously taking notes for how I'm going to message some of these challenges. Can I next hand over to Dr. Catherine Wade, who will be presenting on trajectories for children who experience out-of-home care, examining the influences of pre-care characteristics on late wellbeing and placement stability. Thanks very much, Catherine.

[Catherine Wade] Thanks, Stuart and thanks, Fred. This is the second time I've presented, co-presented with Fred in a month, and it's very intimidating. So we know from past research that children in care are at greater risk of negative life outcomes in a lot of ways compared to other children, and this includes in physical and mental health, socio-emotional health and behavioural problems, but also in cognitive functioning and in a range of other areas as well, but that's not to say it's all doom and gloom. Many children in care do well. We know that. We have that data too, and we think that protective factors play a really important role here, and it's probably the interplay of those risk, early childhood, early life circumstances and negative factors in a child's life, early in their life and the protective factors, the interplay between those two things that really impact the longer term wellbeing outcomes of children in care, and knowing more about the interactions between the different combinations of pre-care factors and within-care factors, we think will help policy makers like yourselves, and service providers and decision makers make informed decisions about placement restoration and permanency planning. But therefore, we need a way of analysing the data that takes this complexity into account, so this complexity of risk and protective factors into account, and that's what we tried to do with the analysis that we did of the POCLS data. So we explored how socio-economic status, Aboriginality, disability, and the age of entry of a child into care, how they interacted to influence child wellbeing and placement stability over time for children in the POCLS sample, and we used cluster analysis to identify groups of children who clustered together, who sort of grouped together based on distinct demographic characteristics on entry into care, and then we used a technique called latent growth curve modelling to examine the trajectories of change for those different clusters. So latent growth curve modelling is quite a sophisticated technique that allows us to do a bit more than just look at mean scores and mean trajectories in a linear sense. It tries to find a latent or underlying explanation for over multiple wave changes in children's outcomes. So it was quite a useful technique in looking at this question of longer-term trajectories. So first of all, just cutting to the results now, the cluster analysis revealed three distinct clusters of children in the sample that we looked at based on those early childhood characteristics and early life circumstances. The largest cluster was around 40% of the sample, and we labelled this, the multiple risk factors cluster, because these children were, on average, more likely to have a disability, more likely to have a lower socio-economic status score on entry into care, and they also tended to be younger at entry into care, so a mean age of around a year old when they entered care, and they were more likely to be Aboriginal or a Torres Strait Islander child. Another cluster similarly size, slightly smaller, but close to 40%, we labelled young at entry, higher SES. So as the name suggests, these children were also young on entry, around about one year. They were distinct from that first cluster because they tended to come from higher socio-economic backgrounds on entry into care, and then the third cluster was around 20% of the sample could be grouped together, and the distinguishing feature of that cluster was that they were older on entry into care. There was quite a bit of big variability in ages, but the mean age was around seven and a half years at the time that they entered care. So after the cluster analysis, we looked at the different trajectories of these children, and in terms of what their cognitive functioning looked like, so these are scores on the Peabody Picture Vocabulary Test, but also looked at their CBCL scores, total problem behaviour scores. So that's socio-emotional functioning and behavioural problems. We compared how the different clusters performed compared to each other and compared to the sample overall. Children who entered care at a younger age and who also tended to have that higher SES on entry into care, they had consistently higher cognitive functioning scores at all waves than the other clusters, and then the sample overall. Children who entered care at an older age had the lowest cognitive functioning scores at wave two, but their cognitive functioning trajectory at later stages aligned closely with the overall sample. So even though they had a lower starting point, and that lower starting point often meant that they didn't quite catch up to the mean of the younger on entry care group by wave four, but their trajectory of change was steeper than the other clusters. Also, the older at entry cluster show a decrease in behaviour problems over time and a flattening of behaviour problem scores by Wave Four when their scores show similar means as the best performing cluster, which was that younger on entry higher SES cluster. So despite early deficits in socio-emotional and cognitive functioning for children who enter care when they're older, these children showed some of the greatest improvements by Wave Four. These findings challenged some of the assumptions and past research that placing children into care at an older age is risky and that decisions about child placement and the achievement of permanency needs to occur in the child is young. Children who enter care after the age of six years do show improvements in cognitive functioning and socio-emotional wellbeing, sometimes with results that are indistinguishable from other children placed in out-of-home care much earlier in their lives, but it's important to note that children in that multiple risk group demonstrated little growth in their cognitive functioning trajectory over waves and they showed some of the poorest socio-emotional wellbeing at Wave Four. So that's that third cluster. Smaller cluster, but still important to consider, and the younger at entry and higher SES and the multiple risk factors clusters both show similar trends towards increasing behaviour problems over time. So that's distinct from that older on entry cluster who showed a decreasing trend in behavioural problems over time. In terms of physical health, there were no differences in the trajectories for physical health between clusters, but despite that, it is worth noting that all clusters showed poorer health at Wave four than at Wave One. The older on entry cluster showed consistently the poorest health ratings of all of the cluster, while the younger at entry higher SES cluster was given the best health ratings at each wave of data collection. I do want to point out though, the measure of health, child health that we used for the analysis has its limitations. It's a single item, a carer rated item. The carer makes a judgement about the child's overall, sort of general health. So it definitely has its limitations. We would like to look at other measures of child health that are available within the POCLS data set to confirm that result, and it will be important to continue to monitor trajectories in cognitive functioning child behaviour and also child health over time with more waves of the POCLS, we think, because even though there were significant cluster differences on many of those cognitive functioning and behaviour problem outcomes, the means for the overall clusters were still within the subclinical range, they were still within the typical range. There's definitely variability, and variability that puts a lot of children in care into the clinical range on those indicators, but it'll be important to see if those trends continue with subsequent waves as the children in the sample overall, but in the clusters age. In terms of placement stability, which is another outcome that we looked at, children entering care had greater placement stability over time. Sorry, children entering care younger had greater placement stability over time, and this is consistent with other research that's found that children who enter care older have a lower likelihood of adoption, they have a greater chance of re-entry into care after a period of restoration with the family. So younger children may be more likely to exit care into restoration, and older on entry children may be more likely to remain in care. Challenges associated with the demands of parenting adolescents are sometimes cited as a reason for this, a reason why there's greater instability for older children or children entering care older, but the findings of our analysis of the POCLS data extend on this a bit by illustrating that for the children who entered care at around seven or seven and a half years of age, they even had greater instability, greater placement moves, a higher number of placement moves in that earlier stage, in that period between Waves Two and Three. This has implications for the types of interventions and supports needed for children in entering care around school age or after school age. We need to consider the type of initial placement carefully in order to plan for transitions if they are required, and paired with a finding that behaviour problems decrease for these older children, older on entry children, this does challenge some of our assumptions about the teenage years as being the critical driver of that placement instability for children who do enter care older, because they certainly don't seem to have the same levels of trajectories of increase in behavioural problems that the younger on entry and multiple risk clusters did. Children in the multiple risk factors cluster did not improve substantially in cognitive functioning scores and their socio-emotional wellbeing and health, worsened over the waves of this study. So they truly were a multiple risk factors cluster with some of the poorest outcomes in the analysis that we performed, and this could indicate the need for a greater investment in out-of-home care prevention for these children through targeted earlier intervention for young children with two or more risk factors. I'm pretty sure I'm preaching to the converted there, for the children with the highest risks in those earlier stages when decisions are being made about initial placement into care or remove from the family, that's when the children are at greatest risk, that's when the most careful consideration needs to be made by decision makers like ourselves. Efforts to support the family to keep the child at home through parenting support or temporary placement while safety is addressed might be a solution for these children who have a range of risk factors. Findings regarding the highest, sorry, children at highest risks of poor long term outcomes are relevant to the Aboriginal and Torres Strait Islander child placement principle, I think, which recognises the importance of connections to family, culture, and country, but there are implications for the training and supports made available to kinship carers. Keeping in mind that these multiple risk clusters was distinguishable because one of the risks was identified, one of the characteristics of that cluster was, that it had the largest proportion of Aboriginal or Torres Strait Islander children in that cluster. There's definitely some implications there for the supports that we provide children and their carers entering care with those multiple risks, including for Aboriginal children, and while there are likely benefits of kin placement, we all know that, and Fred touched on this as well, there's some really positive aspects of kinship care for Aboriginal or Torres Strait Islander children. Others have recognised that our service systems definitely have some things that we need to address in terms of the training and support that we provide to kin carers. We need to do better to equip kin carers with the skills and resources that they need to provide care for, often, the most highly vulnerable children in our care systems. So just really quickly in summary, the results of implications for understanding how child characteristics and risk factors on entry into out-of-home care, as well as protective factors before and during care might impact on later child development, and by identifying children with particular early life experiences, we can inform choices for care that promote the likely best outcomes for these children. Thanks, Stuart.

[Stuart Malcher] Thank you. Fascinating. Many questions I'm jotting down. I'll hold onto those and come back to you later, but yeah, thank you, Catherine, for that presentation. Our third and final presentation for this morning, can I now hand over to Dr. Anne-Marie Laslett, and she'll be presenting to us on substance misuse by birth parents, outcomes for children placed in out-of-home care. Over to you, Anne-Marie.

[Anne-Marie Laslett] Thanks, Stuart. Yes, I'm joining from the unceded lands of the Wurundjeri Woi Wurrung people, and acknowledge them as the traditional owners of the land and pay my respects to their Elders past, present, and emerging, and especially those who are here today, and also, I'd like to say hello to everyone else who's been kind enough to attend the Panel. I feel a little bit nervous. I mean, I'm working the alcohol research space most of the time, but I have had a long-term interest in how the effects of alcohol and other drugs affect children and families and others. So many children entering out-of-home care do have birth parents with a history of alcohol and other drug use, and yet, little guidance is currently provided for children and their birth and current families, as well as little advice being provided sometimes to child protection providers and systems. So we, in our study, look to test a few hypotheses that children in out-of-home care with a history of parental substance misuse were likely to return poorer development of scores compared to those without such a history. So we compared the key developmental outcomes over time available within the POCLS between those two subgroups, those with and without a history of birth parent substance use. We expected that this group might have worse outcomes, but in contrast to our hypotheses, we found that children in out-of-home care with a history of parental substance use were more likely to be in the typical range for cognitive development compared to those without such a history. So this causes us to question a little bit about policy and practice. We also found that in addition, younger children with a record of parental substance use misuse exhibited significantly more typical fine and gross motor skill development than those without this history. That's when comparing to the other children in out-of-home care, of course. So in summary, children in out-of-home care with a family history of substance abuse were the subject of more reports prior to entry of risk reports into out-of-home care. They were older upon entering out-of-home care, they were more likely to be placed into relative or kinship care, and they were more likely to experience typical development compared to those in out-of-home care, but also in comparison to those in the general population when we looked at the developmental scales and the outcome areas tested. So that's not all outcomes, but just that those outcomes that we looked at and that were available in POCLS, and that included emotional, non-verbal, and verbal cognitive and physical outcomes. We also found that they were significantly less likely to require clinical assistance for their verbal cognitive developmental concerns, and for those in the youngest group, they were less likely to require assistance with gross motor skill development, and that they were more likely to be restored to their birth parents compared to other children pasting out-of-home care. So this suggests that, I mean, whilst there is this background in research that suggests that children exposed to substance use early on were at a range of long-term negative outcomes and that this group may be at risk of other adverse outcomes that are not mentioned here, later on in life, they may be at increased risk of taking risk-taking behaviours themselves or have anti-social behaviour, tendencies, or have increased risk of mental health problems, that this group, in some ways, our findings were not consistent with this past research. I mean, in a sense, I think our results place current practice in somewhat of a new light, but needs to be nuanced. So at this stage, it appears that children in out-of-home care with a family history of substance misuse are being managed relatively suitably with regards to their development, and maybe this is because these children have been more ably managed well in care, being older upon entering, being more likely to be placed with relatives and kin, and it may also be that these children, for whatever reason, have been less affected by their experienced trauma, despite being the subjects of more ROSH reports or more reports. So I think this leads us to think about how we use and implement relative or kinship care more widely and where possible, particularly given, it seems that these children are experiencing more typical levels of development whilst in out-of-home care. These care arrangements are often longer and possibly more stable, and may contribute to the better outcomes as a result. However, there's some questions about this. There may be a selection effect, as described by Delfabbro, where children placed into relative kinship care have fewer issues to begin with. So we might need to do further investigation to evaluate the efficacy of relative kinship care over other forms of foster care. It's also important to note that alcohol use can relate to a range of other harms that children may be better protected of if they are removed from their birth parents, but our results show that they weren't developmentally likely to be worse off if they were, if they were removed from those families, I think. So considering the risks that may occur for children remaining in or returning to households with a family member or carer with substance use issues, it's important to assess the care and support needs of the children, and yes, I think I'm going to say again, results indicate that children placed in out-of-home care with a parental history of substance use were the subject of more ROSH reports. So in seeking to minimise these risks and given that children with this parental history do better in out-of-home care in terms of their developmental outcomes, our findings support the notion that children in these situations may be significantly better off and placed into out of-home-care, and alternatively, the substantial disparity in the number of reports may be a reflection of the levels of surveillance that these children are experiencing because their parents have used alcohol and other drugs, which can be a factor, as described by other Australian researchers. So given the positive signs with regards to development outcomes, there was an increased likelihood of children being restored to birth parents. Still, this was only around 19% of children were restored to birth parents. So this suggests that some of the issues, the potential risks of harm have been resolved for children of parents with substance misuse issues, and so, that's why they may be returning to care. It may be, also, that ongoing concerns for the children's child developmental outcomes have been allayed or partly allayed, and hence, they've gone on, been restored to their birth parents. Keep clear that we still need to do further investigations to evaluate the impact of this parental substance use and misuse in the longer term to assess and clarify what constitutes sufficient substance misuse to justify removal in the first place, and then to potentially enable return to birth parents, or what resolution of those issues might be needed before children can be returned to their birth parents. So I guess, finally, it is a balance between managing the potential adverse outcomes and allowing children to remain with or return to their birth parents. Our findings suggest rethinking of some of these aspects of practice, but further research is still needed because the POCLS data that we've looked at has looked at a narrow range of developmental outcomes and found no difference between other children and in out-of-home care, and relative to the general population, no adverse effects in those particular outcomes, but that doesn't mean that in the future, we shouldn't continue to focus on longer term health, educational justice, and substance use outcomes of children in adolescence and beyond who ended out-of-home care with this history. Thank you.

[Stuart Malcher] Thank you, Anne-Marie, for the presentation. Let's take a moment to thank again, our three presenters. Thank you to Professor Fred Wulczyn, to Dr. Catherine Wade, and to Dr. Anne-Marie Laslett.