Royal Commission
into Family Violence

WITNESS STATEMENT OF PATRICIA BROWN

I, Patricia Brown, Director of the Children's Court Clinic of Victoria, 477 Little Lonsdale Street, Melbourne, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am a clinical and forensic psychologist.

3. I am the Director of the Children's Court Clinic, a role that I have been in since 1992.

4. My responsibilities include making available to the Children's Court, state-wide, expert opinion from various specialities of psychology and psychiatry, including my own, for the purposes of informing a magistrate's decision. The clinical assessment of parties to a Children's Court matter can also provide a critical opportunity to facilitate positive change for those individuals.

5. The Director of the Clinic, in consultation with the Court and with the CEO of the Children's Court Services Victoria (**CSV**), determines the parameters of the Clinic's functioning; oversees the quality of its work; represents the Children's Court Clinic variously; leads the service; contributing to professional knowledge and debate within the field at conferences in Australia and overseas.

6. The Director reads the material pertaining to each case, criminal or protection, referred to the Court Clinic; allocates the case according to its needs; and vets each report before it is submitted to the Court. I ensure a kindness in reporting and a balanced view of positive and negative aspects of family life and that the good of the child is the central focus of assessments. I also ensure that Clinic staff are denoted specialists in clinical, forensic and neuro-psychology and psychiatry and that the reports emanating from the Clinic are independent from those from any other agency, but that the Clinic consults as needed to get well rounded information.

7. I oversee a small treatment function at the Court Clinic, the Clinic drug program for juveniles, crisis intervention in the Court's cells and support a research function in the Court Clinic.

8. I also teach seasonally in University doctoral programs.

Background and qualifications

9. My qualifications include a Bachelor of Arts (Honours) from The University of Melbourne, a Master of Clinical Psychology from The University of Melbourne, and a PhD in Psychology from The University of Melbourne.

10. I have been a Visiting Fellow at The University of Melbourne and I was elected to Fellowship of the Australian Psychological Society (**APS**) in 1994. I was material to the setting up of the Board, now College, of Forensic Psychology in Australia. In its inaugural year, I was the Chairman of the Board of Forensic Psychologists.

11. The Children's Court Clinic has been the central focus of my professional life. I have worked in the Children's Court Clinic for the past 50 years.

12. In 1992, I instituted a new direction for the Court Clinic reporting process.

13. Prior to 1992, the Children's Court Clinic was a psychiatric clinic managed after a medical model of illness, and a psychiatric team approach. The personnel reflected the model: there being a psychiatrist superintendent, consultant psychiatrists, a medical officer, or regular nurse, two psychiatric nurses, three psychologists and two social workers, all of whom worked full time. Treatment in institutions was emphasized and assessment and treatment could be undertaken for multiple referrers, including those self-referred from among the public. The model of service and the professionals employed would have been suited in training to an exclusively psychiatric population, yet the population at the Court Clinic had a limited number of psychiatric problems referred by the Court; there being rather a predominance of learning and social problems related to disadvantage. Further, matters referred from the Children's Court for assessment were becoming more numerous, complex and specialized, and the staff at the Court Clinic were occupied with treatment that should have been provided from agencies beyond the Clinic. It was felt that the Clinic should be restructured to deal exclusively with the assessments referred from the Children's Court and to have only a small window for short-term treatment in selected cases still before the Court.

14. In terms of disciplines of choice for staffing, the findings from two researches commissioned in 1988, looking at the efficacy of Court reports for Sir John Starke's Sentencing Committee, informed the choice. Findings from the first research showed that judges and magistrates, while appreciating the reports of social workers, pointed out that their reports accompanied most offenders, and so they wanted to have reports from psychologists and psychiatrists. The second research which involved blind ratings of the reports of psychiatrists, psychologists and social workers resulted in the reports of psychologists being rated as most efficacious for the Children's Court.

15. In 1992, I was appointed as Director of the Children's Court Clinic and set about establishing a largely psychological service with senior psychologists progressively appointed on staff. Additionally, I arranged for sessional clinicians, psychiatrists for adults and older adolescents, psychiatrists for children, and clinical, forensic and neuro-psychologists to be employed on a needs basis, and to include persons who were specialists in particular problems. The aim was to have doctorally qualified specialists with ten years of experience for both full-time staff and sessional staff. Rather than a team approach (since it is difficult for a Judicial Officer to know who contributed what to a recommendation from a team) each clinician was to be responsible to the Court for his/her work but the work was to have oversight from the Director of the Clinic. The new model of the Court Clinic allowed the right professional discipline to be applied to the case, for those trained in learning and social models and in mental illness, and an independent practitioner model. Assessment (and treatment) for the Court and only by Court Order was established exclusively.

16. In 2000, I received a Public Service Medal in the Australia Day Awards "For Outstanding Service to the Children's Court Clinic". In 2002, I received the APS Ian Campbell Prize for excellence in applied clinical psychology in Australia. In 2007, I was recognised by the College of Forensic Psychologists for "Distinguished Contributions to Forensic Psychology".

17. I have authored a number of academic articles and papers on clinical and forensic psychology, including on the role and practice of psychologists in the court process.[1] I have lectured within doctoral psychology courses at various universities in Victoria, and within the Department of Criminology at The University of Melbourne. I have supervised clinical and forensic doctoral students and examined doctoral theses.

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1 See examples in Appendix.

Children's Court Clinic

18. As indicated above, the Children's Court Clinic is an independent organisation that conducts psychological and psychiatric assessments of children and families for the Children's Court. In some cases, therapeutic treatment is also provided.

19. The Clinic also conducts assessments relating to the impact of drug use on a young person and may make recommendations about appropriate treatment and conduct that treatment. The reports provided by the Clinic are used to assist magistrates in making decisions in both Family Division and Criminal Division cases.

Referrals to the Clinic

20. Only a magistrate can refer a matter to the Clinic for assessment. This means that the Clinic only deals with cases which are before the court, either because a protection application has been made by the Department of Health and Human Services (**DHHS**), or because a young person has been charged with criminal offences.

21. If the matter is "before proof", that is, at an early stage of the proceeding before it has been established on the evidence that a child is in need of protection, the referral must be made with the consent of the parties. However if it is post proof, a magistrate can send the matter to the Clinic absent that agreement.

22. Staff from DHHS, lawyers and parents can all request that a magistrate refer a matter to the Clinic.

23. There are no protocols around the kind of cases that will be referred to the Clinic, however this has never been a particular concern of mine, because the cases that are referred to us are all very pertinent.

Terms of Reference

24. With the exception of some matters referred to the Clinic from country Courts, the cases we see usually come with "terms of reference". The terms of reference operate as a direction to the Clinic to look at particular areas which are of interest to the referring Magistrate.

25. The terms of reference might require the Clinic to assess the safety of the child in the home; the risk to the child in the home; parenting capacity; things of that kind.

Whether violence is specifically highlighted as something we must look at, it will be assessed through a consideration of any of those factors. The extent to which a child does not feel safe, for instance, necessitates some assessment of whether there has been any violence and if there has, what effect that violence has had.

26. The identification of terms of reference does not mean that we do not provide an overview of the totality of the situation to the Court. Our reports provide the historical context of what has happened in the lives of the people concerned. Based on the process set out below, the Clinic will form conclusions about the issues specifically raised in the terms of reference, and we will slot those conclusions in to the context of an overview of the family as a whole.

Interview process

27. What the Clinic does, firstly, is interview the people concerned. We will interview the parents and children, often the grandparents, and any carers or a DHHS worker involved. We observe the family in their interactions with each other and with us, and we observe them technically when they're not interacting with us. Sometimes we will administer psychological tests as well.

28. The Clinic interviews people for about five hours, sometimes longer. When interviewing, we see people in different combinations: we will interview the mother alone, the father alone; the mother and the father together; the mother, father and child; each child alone; grandparents inside and out of the room – and we are watching the child all the time. We will comment on what the child does when these individuals enter and exit a room; on what happens when they catch sight of their parents; whether they spontaneously run up to the parent, for instance. That response can be one indicator of the level of emotional connectedness between the child and each parent.

29. We listen carefully to what people tell us during that interview process. We do pay particular attention to any disclosures of violence, and we will ask about it, but we are careful how we ask. We would never say to a husband "do you beat your wife?" In the course of five hours, if you engage with people, they will tell you a great deal, and you are able to elicit that kind of information quite readily. Of course, we warn them that everything they tell us can go into our report, however a good clinician will gain the trust of the people they are interviewing.

30. Children can reveal the presence of family violence without stating it directly. They can show it in their drawings, and they can show it when they're playing. We have doll houses, for instance, and we will watch what one doll does to another. Sometimes it is "bang, smack, push them into bed". We are making an assumption that that behaviour is reflective of what they have witnessed in the home, however the assumption is often backed up by other things we observe. If the child is very small, or a baby, it is suggestive of problem if the child avoids gaze, or if they arch their body away from anywhere near their mother's face. There can be other explanations for this as well, but the child might be telling you that things are very uncomfortable with mother. We look at all of those kinds of things.

31. As with other potent issues like sexual abuse, for example, I am always reluctant to infer that violence is present, without there being reasonable evidence of it. Fortunately we at the Clinic do not have to notify often since, if there is violence, DHHS will have picked it up in their investigations. If they have not, we follow through in initially investigating through the family members we are seeing in the case and it will appear in our report. Several factors need to be taken into account when reporting on violence, for example, whether:

    31.1. there are protective factors in the home to try to compensate for the violence;

    31.2. it is of a nature that some would not deem it violence;

    31.3. the violence is situational and related to the presence of only one person;

    31.4. the violence is seldom experienced and so forth.

32. Where it is full blown violence, frightening and experienced often, a child needs to be protected from it continuing, otherwise it can potentially affect the child's normal development; cognitively and socially, and including the child's attachment relationships.

33. Sometimes we have to go to great lengths to get a fair picture of a child's bond with a parent. I recall one instance where a maternal grandmother had been alienating the children against their father and we had seen evidence of this in the waiting room. The Court had ordered us to evaluate the relationship between the children and the father, however when I proposed to the children that "perhaps we might see Daddy", they started to cry. I thought 'Ok, we can't do this. They're so against it'. So what I did was bring in the little Clinic dog, which we have sometimes, which kisses

everybody and left them to play for about ten minutes. There were peals of laughter, they had a lovely time. When I went back in and asked "do you think we might see Daddy now?" They said "Yes alright. We will see Daddy". In that scenario, we needed to change the context to get an accurate appraisal of the situation.

34. We do see that kind of alienation going on, but at times, the desire not to see a parent who has been violent is quite real. For those children, they may have given up hope that a parent may change their violent ways and/or they feel afraid of the parent. If that is the case, we will report it to the Court. However when there seems to be evidence of some hope for change in the child's mind, and the possibility for turn-around exists, we will tell the Court what might be needed for that change to occur. We look for examples of what might be improved, and how it might be improved. This might include demonstrated changes in a violent parent's situation.

Information gathering

35. We will read any report that is relevant to the family, including a DHHS report, and gather any other relevant information from the various professionals who may have been involved. We will speak to hospitals, particularly if there has been a mental health admission, and we will seek the consent of the parents to speak to the children's school. We collect as much data in relation to the family as possible. That data informs the conclusions in our report.

36. In this way, the Clinic fills evidentiary gaps that otherwise may not be addressed. In circumstances where the overwhelming majority of representation in the Court comes from Legal Aid, and there are not a lot of resources for subpoenas or other evidence gathering, the Court may well not have the information if we do not provide it.

37. If we have not been able to speak to a person, because they refuse to speak with us, or if the parents have declined our request to contact them, and they are material to the family, then we will note that in our report as well.

Clinic reports

38. We provide our report to the Court for the purposes of its judgment. It is the Court that owns the report. Attached to this statement and marked **"CONFIDENTIAL PB-1"** are copies of two de-identified reports prepared by the Clinic for the Children's Court, with names, dates and areas changed. The overall work-up of a report takes approximately 31 hours, which includes all the reading, telephoning for collateral

information, observations, interviewing, test administration and the writing of the report.

39. Following a Children's Court decision, the parties may request a copy of the report from the Court, not from the Clinic. Generally, the reports are disseminated only to the lawyers of the parties, not to the parties themselves, except that DHHS is normally given a copy by the Court.

40. In certain circumstances, we will prepare reports that say to the Court, there is information contained within this document that should not be made available to the parties. Difficulties can arise when parties are self-represented and our report has to be made available to afford them natural justice. Our dilemma is then how much information should we then put into that report. We may know, from what the woman has told us, that her partner belts her every time he drinks liquor, but if we put that into the report, he may belt her significantly because she has spoken about it.

41. Factual issues must go into the substantive part of the report, however in relation to more peripheral issues that we believe the Court nevertheless needs to know, we have to consider carefully how we can best present that information.

42. We also prepare an abridged version of the report; a summary document, which is released for funding purposes so that Victoria Legal Aid can assess whether the case will continue to receive funding.

Treatment

43. The majority of our work at the Clinic is focused on providing an assessment report to the Court. However, as suggested, we do have a small window of opportunity to provide treatment to the people that we see.

44. In certain circumstances, we will ask the Court for an interim order, allowing us three months or so to provide treatment, either of a person or of a family. Where you are treating an entire family, you can hive off one person to do a particular treatment with, then you can provide therapy at a family level.

45. We ask for this interim order to see whether the intervention the Clinic makes can lead to a different recommendation being able to be put to the Court in our final report.

46. If you have a child who refuses to see a parent for particular reasons, and those reasons seem questionable, we would want to attempt to remedy that situation with

treatment. We may be able to get a parent to change their actions or assist a child to see things differently.

47. I have long worried, given we see a strong nexus between violence and drug/alcohol use, as detailed below, that we do not have a closed drug treatment facility for young people. If we send someone to a drug facility, they can simply walk in the front door and out the back. Young people seldom want to change their drug use; they don't want to stop. We have a cohort of adolescents that requires therapeutic assistance within a closed facility, where you can have intensive input with them, and try to assist them meaningfully. I commend to the Royal Commission the work of Magistrate Jennifer Bowles of the Children's Court of Victoria, whose Churchill Fellowship report upon various mandatory youth treatment facilities in Sweden, Scotland, England and New Zealand is important.

Clinicians

48. I have pointed out that the majority of our clinicians are clinical, neuropsychological or forensic psychologists. We also use psychiatrists. We normally have a complement of five specialists who are full time, including myself, although at present we have only two full-time clinicians and one other for two days per week, in addition to myself for the Clinic, state wide, because of funding strictures. There are also 45 sessional staff who have a variety of specialties, for example, there are among them experts in arson, in drug and alcohol matters, in sexual abuse, in babies and small children, and so forth. Their availability is always variable, since they have other employments in hospitals, universities and private practice, and the court time-lines for a case may be prohibitive for the sessional clinicians' own work commitments. In the event of needing to contact, say five clinicians in turn, none of whom can pick up the case, it may then have to fall to the full-time staff, the numbers of whom are depleted.

49. At the present time, the requirements for inclusion on staff at the Court Clinic remain a doctorate and ten years of experience and 77%, have those qualifications. I also retain seven clinicians, employed because of their standing in the field, who have a masters degree in psychology and very considerable experience.

50. All our clinicians, full-time and sessional, are denoted specialists.

Cohort of people referred to the Clinic

51. I am myopic in relation to the kinds of people that come through the Children's Court: I see only the sub-sample of people that are referred to the Clinic, which may or may not be representative of who comes through the Court more generally.

52. I have observed that we are increasingly seeing more and more complex cases at the Clinic. Even since the 1990s, the people we are seeing have many more and complex problems in living. I do not think that the apparent complexity is solely attributable to the fact that we are becoming more sensitive to particular areas, including family violence. Generally speaking, I think things are worse than they were before. I am greatly concerned about the degree of violence that we see, the degree of poverty, isolation, early exiting from school, lack of employment for adolescents and parents alike, and the lack of housing.

53. In the past fortnight, there has been at least one mother who has rung up and said "I can't get to the Clinic, I have no money. I am about to be evicted". The poverty we see is extraordinary, much more than people understand, and it is getting more acute. We see people who are living in cars, and who have had their children taken away for that very reason. There can be quite a family connectedness within these families; it is just that they have lost a place to live. The only thing that they have is a car and each other. From my perspective, it is criminal for children to be taken away from their parents because they are living in their car. What the State should have been doing was seeing that these families get housing, not separating them.

54. In many of the Clinic cases, the men have no work and this leaves them feeling disempowered, and liable to take it out on those less powerful. The women have often never worked, not because they were not cognitively able to do so, but rather because life opportunities have been such that they have been isolated in the home. Perhaps they had children at a young age or are with a controlling partner. By the time they get to their feet and could be employed, they don't know how to apply for a job; to dress for an interview or to speak for themselves. These women are condemned to a life of poverty. It becomes difficult for them to go anywhere else when problems arise in the home. Often we find there is disaffection in the extended family, and that may be the reason for their isolation or it may be because they had children young. They may have left the family at a young age, because there were problems in the family of origin. Sometimes the women will not have the wherewithal to tell people something is wrong. They are often too ashamed.

55. Chrystal methamphetamine, or Ice, has also brought a new dimension to the people we see. Ice has led to enormous violence and I am greatly concerned about what we can do about it. It is changing both the behaviour of young people in criminal matters and in Crimes Family Violence, and the behaviour of parents, who may also be young, in protection matters. We see people who have been recruited to make Ice: juveniles who suddenly have an enormous amount of money. These are young people who were previously very poor. Suddenly there is a carrot, access to considerable money, if they will take part in making Ice.

Family violence

56. In my experience, the majority of cases referred to the Clinic involve violence in the family unit.

57. However it is rare that violence is the only issue in the cases that are referred to the Clinic. Typically there would be a number of issues at play, including intergenerational poverty and associated alcohol and drug issues, and this is reflected in the broad terms of reference we see today.

58. For the purposes of the Royal Commission, we considered the first 100 protection matters of 2015 and counted the number that involved violence. Of that 100, 69 involved violence in some form, most often by a parent but at times by an adolescent in the family.

Family violence and the best interests of the child

59. If family violence is absolutely blatant and ongoing, with physical altercations happening regularly in front of the child, then that child is unsafe. Where there is abject and ongoing violence, you cannot leave that child in the home.

60. However, in the majority of cases we see, it is much more nuanced than that. There are great gradations of violence. Sometimes the more terrifying violence is verbal in the presence of children who are old enough to understand the significance of the words that are used. Irrespective of age, children will always understand and shy away from threatening tone, as do also the family's pets.

61. Balancing the risk posed to the child by remaining in circumstances of family violence against the risk posed by being removed from the family is a terribly difficult task. It requires a careful consideration of the connection between the parent and child. I do not think you can negate the love between a child and a parent: a child will forgive a

parent a great deal. We run the risk always of breaking a child's heart, if you take a child away and that child is never returned. We need always to try to establish and recommend the least worst alternative.

62. If there is an attachment between the parent and child, we have to bear in mind that if the violence is still continuing, that attachment may not be sufficient to make it appropriate to leave the child with the family. In considering the removal of a child, we have to consider also what will happen if there is not an appropriate carer straight away. We assess whether it is so bad for this child to be living with the family, as opposed to being taken away from home, which may well entail a number of moves for the child; serial placements. It is not as simple as putting the child into another household. The issue of attachment and contact for a child with the parent is extremely concerning for me and for the other Court Clinic clinicians, as is the potential for a child to end up in a Residential unit, as has recently been happening even for children of seven and nine years of age.

63. It is almost an institutionalised form of violence, emotional violence, to take a child away from a parent unnecessarily. The Children's Court has always been very sensitive to the issues surrounding family violence, in my experience, and this is demonstrated by the very considered and careful judgments that the Court hands down. There is, however, considerable disquiet in the field now about the *Children, Youth and Families Act Amendment (Permanent Care and Other Matters) Act 2014* (Vic) (**Amendment Act**), which is to commence on 1 March 2016, because it limits considerably the powers of the magistrates whose judgments have been such a help to the lives of children.

64. Certainly, there are circumstances where it is appropriate for the child to be taken away, but you need to put a remedial process in action immediately to help the parent, and this is where the system falls down terribly. We should be employing a preventative system, however the community seems tolerant of, or uninformed about, what is lacking for disadvantaged families. It is very significant that the Amendment Act will no longer require the DHHS to provide or arrange services for families.

Community attitudes & violence prevention

65. I do not know how you divorce family violence from culture. There are cultural imperatives in Australia that are permissive of male violence, and a refusal to see

that females can be violent also. The existence of female perpetrated violence does not negate the fact that most violence comes from men, and certainly because of their physical power, the more serious violence in particular, however we certainly see females who have been violent towards their children. That is not something that is very widely acknowledged by society.

66. Our culture allows men to be violent. I think the messages in the community, through television, film, advertising, computer games and even sport celebrate violence. If you make a character an anti-hero and he kills, brutally, a person you have come to know in the film, that's violence and there must be a way of countering it because it desensitizes people to violence.

67. I believe that there is a role for schools to play in countering violence at an early stage. The issues and consequences of violence should be in the school curricula, to be discussed by students to create an awareness around it.

68. Schools and society more generally also need to be more proactive in ensuring that children stay on at school. There is an important literature that demonstrates that if children stay in school, they are not going to get into trouble to the same extent as if they leave. There is no need to be a star pupil, just to stay engaged in schooling. Often the people who fall out of school have been difficult when they did attend, and that is why they are not pursued to return. Often they have learning disabilities, and we have seen the assistance for children with learning disabilities evaporate in the last ten or fifteen years. These children then stay at home and become alienated from the normal community. They may get into drugs, and if they have already had violence in the house, it becomes somehow permissible to use violence. They start to put holes in walls, and demand money for drugs, in a household that hasn't got any money anyway. Then they start to commit thefts and robberies outside of the home. It is a cycle, and schools are implicated in this when they let adolescents leave without trying to retain them because they are troublesome.

69. I do not think you can tackle violence by blaming the person being violent, either. You never really get through to another human being by criticising them. Acceptance of the person and not the action is basic but sometimes humanly hard to do. Helping to restore people's dignity by helping them in a number of areas in living is the way to reel them in, as it were, for change to their thinking. Then you teach them better ways of dealing with their anger and frustration and their shame. Unfortunately, in the most disturbed, and disturbed over a lifetime, violence can become part of the

personality, and the opportunity for change is narrow indeed, and would require years of remediation. That is why Anger Management groups will be useful only for some men who behave violently. Violent men need to be a part of a community shift as well, so that they as people (and not their violence) are normalised in the community, rather than being secluded at home, with no work and feeling disenfranchised.

70. I also think we need to be more supportive of vulnerable women who seek assistance. The first port of call for many vulnerable women will be maternal and child health nurses, their doctor, or their children's schools. However because of mandatory reporting to DHHS, those professionals can potentially be seen on the grapevine of those who are disadvantaged as participants in a collusive system, working against those that need their support. It follows that suspicions arise that if you tell anybody that you need help, Welfare will come and get your child. Many times we have had women say to us, "I was desperate, I didn't know where else to turn so I rang Community Services thinking that they would come and help me. What they did instead was take my child." That is so common that any of our clinicians will tell you they have heard it numerous times. I do understand why mandatory reporting was introduced; we must always put the child first, but I think it has done a disservice to many women who could have done with immediate, carefully crafted help, so that the child was protected and real help was forthcoming.

Community engagement

71. There are community programs that can be implemented to reduce isolation and increase community support, so that people are not reliant on statutory services to access the help that they need.

72. I recall attending a talk by a retired Professor of Psychology, Dr Gary Melton, Director of the Institute of Family and Neighbourhood Life in the United States, about five or so years ago, who had, after his retirement, taken it upon himself to try and improve community engagement by establishing a kind of social hub. Dr Melton had looked around his town and identified that the local Fire Station could serve as an informal drop-in centre. He decided upon the Fire Station because he realised that fireman were young, capable people, respected by their community, and who would be present at the Station in between fighting fires. With the eventual support of the Fire Chief of the State, a wonderful system was set up that allowed people to meet and share a coffee in a neutral setting. Older women, who had reared children and knew how to raise a family, but who now had few social engagements being more isolated

as they grew older, were introduced to other like people and to younger people to whom they could provide advice, advice about babies and child rearing and family life. People grew to know other people from their street. So successful was it that after a little time had passed, people would go and visit others who had not yet attended, and invite them to come along.

73. We require models of support, like that described above, that go beyond just social housing. I think that these programs should be placed in the hands of local councils, to foster community engagement on that local level, as I do not think that councils are brought into these matters sufficiently, and they could be such a good resource. Councils could help people to establish networks of support, or to become employed locally, for instance. That sort of support is largely lacking from our community at present.

.....Patricia A. Brown.....

Dr Patricia Brown

Dated: 6 August 2015

APPENDIX

Examples of academic articles and papers

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