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The Parliamentary Officer
Select Committee into Stillbirth in South Australia
GPO Box 572
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Submitted via email to: scstillbirth@parliament.sa.gov.au

Dear Members of the Select Committee into Stillbirth in South Australia,

APS response to the Select Committee Inquiry into Stillbirth in South Australia

The Australian Psychological Society (APS) welcomes the opportunity to provide this submission to the South Australian (SA) Government Stillbirth Inquiry. We commend the SA Government for addressing this profoundly important issue, which can have devastating effects on parents, families, kin and communities.

About the APS

The APS is the leading professional association for psychologists in Australia. We are committed to advancing the science, ethical practice and application of psychology to promote health and wellbeing, prevent issues and deliver early intervention and treatment, empowering individuals, organisations and communities to reach their full potential. Our work is informed by United Nations human rights treaties and conventions[1] and the United Nations Sustainable Development Goals (SDGs)[2] and Conventions. We advocate for a fair, inclusive and environmentally sustainable world, recognising the evidence that national and global prosperity, now and in the future, hinges on prioritising the wellbeing of people and the planet[3].

Our members work across diverse settings relevant to pregnancy and stillbirth care, including clinical service provision in perinatal mental health and maternity services, community health and private practice. Our members also include academics and researchers. Psychologists are highly skilled and trusted mental health professionals who are uniquely qualified to help address the psychosocial determinants of stillbirth risk; provide trauma-informed, culturally safe evidence-based bereavement care, and design and deliver perinatal care and pregnancy loss education for health professionals.

Please find the APS response to the inquiry terms of reference on the following pages. We consent to this letter and our response being made publicly available. If any further information is required from the APS, I would be happy to be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Yours sincerely

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Chief Executive Officer

Australian Psychological Society (APS) Submission
to the South Australian (SA) Government Stillbirth Inquiry

Conception, pregnancy, birth and the postpartum phase heralds a period of significant physical and psychosocial change for people who are pregnant and their partners, families and kin, including close friends and caregivers. The perinatal period brings joy, but also brings challenges, uncertainties and in some cases, psychosocial stress and increased vulnerabilities for mental ill-health such as perinatal depression, anxiety and post-traumatic stress disorder[4–7].

In the context of stillbirth, the vulnerabilities of the perinatal period are magnified. The sudden and devastating loss of a baby during or after pregnancy can have profound and long-lasting psychological, social and relational impacts[8]. Grieving parents, families and kin may experience intense and prolonged feelings of guilt, sadness, anger and isolation[9]. This grief is often compounded by societal stigma or silence surrounding stillbirth, which can exacerbate feelings of isolation and complicate the grieving process[10]. Stillbirth can disrupt expected family dynamics and relationships, creating additional emotional strain. Partners may experience their own grief while supporting the person who carried the pregnancy, while immediate and extended family and kin may also feel the impact deeply[11]. Stillbirth is a devastating experience with profound, and often long-lasting, psychological, social and emotional impacts for parents, families, kin and their communities.

The perinatal period, already a time of heightened sensitivity, thus becomes a particularly critical opportunity for prevention efforts and the provision of comprehensive care and support for those at risk of pregnancy loss or previously impacted by stillbirth. These opportunities are recognised in the *National Stillbirth Action and Implementation Plan* (2020)[12] which provides a framework for reducing stillbirth rates and enhancing bereavement care through awareness, research, clinical support and education. More recently, the APS-endorsed *Stillbirth Clinical Care Standard*[13] (the Standard)was published by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2022 to guide healthcare services in standardised, evidence-based prevention and care, drawing on nationally endorsed initiatives such as the *Safer Baby Bundle*[14].

As recognised in these national guides, and addressed in more detail in our submission, safe and high-quality stillbirth prevention and care includes timely and sufficient access to evidence-based psychosocial, as well as medical care. This includes culturally safe bereavement care that leverages the expertise of psychologists to help mitigate the impacts of stillbirth and promote healing and resilience. Psychologists are also well positioned to contribute their expertise to proactive health and mental health awareness raising and education initiatives that encourage pregnancy health, both physical and mental, and addresses modifiable risk factors. Psychologists play a key role in multi-disciplinary models of care, supporting and advising other health professionals and providing expert psychosocial care for prevention and early intervention that responds to the needs of parent/s, families, kin and other key supports impacted by stillbirth. Psychologists also play a vital role in training healthcare providers to deliver compassionate and trauma-informed care to those impacted by pregnancy loss, and in advancing research and evaluation to improve stillbirth prevention, intervention and bereavement support efforts.

Response to the Inquiry Terms of Reference

1. Pregnancy Health and Stillbirth Prevention

Relevant Inquiry Terms of Reference

a) *Best practice stillbirth prevention education and awareness programs for expectant parents; including, but not exclusive to, the monitoring of babies in utero.*
b) *Public education programs/initiatives to increase community awareness of stillbirth and where people can access support in the community.*

Identify and respond to psychosocial vulnerabilities as early as possible, and as much as needed, within the perinatal period and beyond

Ongoing assessment and identification of biopsychosocial strengths and vulnerabilities—such as mental health history, social support networks, financial stability, stress levels, previous pregnancy experiences, cultural considerations, access to healthcare and so on—must be a standard component of preconception and perinatal care[5,13]. Embedding routine psychologist-led screening and mental health check-ins within maternity health care settings can assist in early identification and management leading to evidence-based psychological support that enhances and maintains the mental health and wellbeing of parents, families and kin; mitigating against risks associated with pregnancy loss and delivering best-practice bereavement care for stillbirth.

Primary care services, perinatal teams and clinicians (e.g., obstetricians, midwives) providing pregnancy-related care must be aware of the high burden of perinatal mental health disorders and other psychological vulnerabilities such as adverse childhood experiences (ACES), trauma histories (including previous pregnancy-related trauma or stillbirth) or personality difficulties[4] that can heighten stillbirth risks during pregnancy.

Given the complexity of these factors, it is our position that integrating psychologists into multidisciplinary perinatal teams is essential to ensure ongoing and comprehensive identification of psychological risk factors, enable timely treatment planning, and delivery of evidence-based prevention and interventions.

Recommendation 1.

The APS recommends the South Australian Government urgently provides dedicated funding to embed psychologists within state-funded maternity care settings and perinatal teams to ensure timely psychological assessment and evidence-based psychology intervention services for at-risk parents and families. This includes specialised support for subsequent pregnancies following stillbirth, offering continuity of psychological care to manage fear, anxiety and trauma responses.

Raise awareness of pregnancy health and stillbirth prevention and availability of psychological support without causing alarm and distress

It is important to provide culturally accessible information about pregnancy health and stillbirth at the time of conception and throughout pregnancy, directly to parent/s via health professionals and services and also via public education to help reduce the incidence of pregnancy loss and stillbirth[13].

When providing information about pregnancy health and stillbirth prevention, it is important to recognise that approximately 30-40% of stillbirths are still 'unexplained'[15,16]. Over reliance on a pregnant person's behaviour as the main (or only) avenue for pregnancy health and stillbirth prevention risks increased anxiety and unhelpful self-surveillance in the pregnant person. Furthermore, if the pregnancy does end in stillbirth, this may lead to self-blame or guilt, which are common feelings post-stillbirth[17].

Given that many pregnant people are already anxious about the health of their foetus[6] or experience obsessive-compulsive symptoms during pregnancy[7], it is important to balance awareness-raising communication and education carefully. The aim is to encourage healthy monitoring and behaviour without unnecessarily alarming parents, creating undue pressure and or inducing feelings of sole responsibility for the outcome of the pregnancy, which will be counterproductive. Information provided must also include an understanding of factors outside of the pregnant person's control which may determine pregnancy outcome[18]. The early provision of this information can help families cope with late pregnancy loss should this occur. Given the above, it is our position that information provided via public health campaigns or in person should include:

- Evidence-based actions that pregnant parent/s or those planning a pregnancy can take to enhance healthy behaviours, including managing psychosocial stressors and conditions, and reducing modifiable risk factors for pregnancy loss and stillbirth[13,19].
- Messaging and communication that aims to reduce societal silence and stigma associated with pregnancy loss and stillbirth[9].
- Clear signposts to accessible perinatal, pregnancy loss and stillbirth health and psychological support services to ensure people know where and how to access relevant services[13], including increasing their awareness of state and federal government funded services (e.g. Medicare-rebated Non-Directive Pregnancy Support Counselling Service[20]) and NGO services, of which many people may not be aware. Specific help-seeking guidance should be targeted to priority populations such as people in rural and remote areas, First Nations peoples, culturally and linguistically diverse families and kin, and people who identify as LGBTQI+[13].

Recommendation 2.

The APS recommends the South Australian Government urgently fund a public awareness and education campaign that addresses the emotional, social and cultural dimensions of stillbirth. The campaign should be co-designed by psychologists—including health, community, counselling and clinical psychologists and psychology academics and researchers— as experts in applying psychological and behaviour change science to improve engagement, uptake and adherence with health messaging across diverse communities and priority populations. Psychologists can also help shape public messaging that de-stigmatises stillbirth, encourages open dialogue and promote empathy and help-seeking.

2. Best Practice Models of Pregnancy Care and Support After Stillbirth

Relevant Inquiry Terms of Reference

a) Models of care in pregnancy that may contribute to a reduction in stillbirth (including for priority populations).
b) Models for follow-on care (including mental health support or care in subsequent pregnancies) for parents after stillbirth (and infant loss more generally).
c) Support and training for healthcare professionals relating to stillbirth prevention and bereavement care.
d) Best practice regarding stillbirth investigations (including access, information for parents and case review), pathologist training and service provision.

Ensure safe and high-quality bereavement care is available over the longer-term for partners, families, kin and other support people impacted by stillbirth

Consensus about safe, high-quality bereavement care after stillbirth notes that consumers should expect:

- care delivered with compassion,
- that their health care providers have up-to-date training in bereavement care, and
- that clinicians will provide evidence-based bereavement care and referral to expert bereavement care options when needed[21].

High quality bereavement care and support for stillbirth requires advanced-level case formulation and intervention that reflects, not only the losses that are part of stillbirth, but potential future impacts on pregnancies and later parenting. Due to the unique and potentially traumatic experience of stillbirth, it is our position that psychologists with expertise in bereavement care for pregnancy loss and stillbirth are best placed to deliver these services.

There are services such as those in the Centre of Perinatal Excellence (COPE) who can direct affected people to appropriately skilled psychologists and other avenues of skilled support[17].

There is clear evidence that stillbirth has a significant and long-term psychological impact, profoundly affecting emotional wellbeing and daily functioning[9,22,23]. Bereavement care should be proactive and accessible across the short term (e.g., immediate emotional response and informing family and close others), medium term (e.g., returning to work, adjusting to daily life) and longer term, to support not only the person who experienced the pregnancy loss, but also partners, family and kin[23,24].

Despite the benefits of interventions and empathic care[22], less than 50% of parents receive 'follow-up' contact from their hospital[23,25]. Further, many people, families and close others who experience stillbirth feel isolated, and because stillbirth is rarely discussed in public discourse, may suffer in silence, intensifying their distress[18]. Stigma surrounding stillbirth further contributes to this isolation, discouraging support-seeking. Given these challenges, it is essential that the safe, high quality psychological support services are promoted sensitively and are easily accessible throughout all stages of bereavement helping people who have experienced stillbirth to navigate grief, reduce long-term distress and promote emotional recovery.

More acknowledgement of the bereavement support and care needs of partners, families, kin and other key support people, such as close friends and caregivers who play a significant role in the grieving process, is also needed. Partners, family and kin can also be impacted by stillbirth beyond their role as a support to the person who has experienced pregnancy loss[11,17,24,26,27]. For example, partners may be expected to support the person who has experienced pregnancy loss; care for older grieving children and return to work - all whilst often grieving themselves[26]. Similarly, grandparents may experience their own grief, while supporting their children and grandchildren[11].

The Sands Australian Principles of Bereavement Care[28] note:

> *"Principle E: Acknowledging a Partner's and Family's Grief Recognition that a partner's and family's grief can be as profound as that of the mother and that their need for support should be considered and met. It should be clearly communicated to both the mother and her partner that support services are available to them individually and that it is helpful to talk to someone if they require support"* (p. 12).

It is particularly important to recognise the strain the trauma of stillbirth loss can place on the partner, family and other relationships[29] and recognise the need for individual as well as family systems support[29,30] Who constitutes a partner, family or support person should be defined by the person who has experienced the pregnancy loss and be inclusive of diverse families including those from culturally and linguistically diverse backgrounds and those who identify as LGBTQIA+[27,31].

However, some services may not align well with the delivery of culturally safe models of care for First Nations peoples or culturally and linguistically diverse families, or have eligibility criteria that exclude LGBTIQ families. For example, the Federal Government's *Non-directive Pregnancy Support Counselling Service*[20] offers Medicare-rebated access to up to three 30-minute sessions with an eligible clinician, including psychologists, for individuals who are currently pregnant or have been pregnant in the past 12 months, including those who have experienced stillbirth. Partners of eligible patients may attend each or any counselling session, but not on their own. To enhance program inclusivity the APS has advocated for expanded eligibility to be inclusive of:

- partners, non-birthing intended parents (e.g., in surrogacy cases), and other family members and kin affected by pregnancy loss, including stillbirth; and
- those above who have experienced stillbirth or perinatal loss beyond the current 12-month post-pregnancy timeframe, ensuring long-term access to care when needed.

The APS has also advocated for an increase to the number of sessions, given the current limit of three sessions will generally be insufficient for individuals experiencing complex or prolonged distress related to pregnancy and may limit the delivery of inclusive and culturally safe practices for stillbirth care for First Nations peoples. Structurally non-inclusive service systems can reduce all help-seeking due to anticipated discrimination or lack of cultural safety[32–34].

Recommendation 3.

To ensure timely and effective support at critical stages of grief and adjustment after stillbirth, reduce long-term distress and improve mental health outcomes for all parents, families and kin, the APS recommends that the South Australian government:

- *Urgently review and expand, where necessary, eligibility criteria and funding for state-funded psychological services to ensure comprehensive support for diverse parents, families and kin affected by stillbirth, and*
- *Advocate for an urgent review of the federally funded Non-directive Pregnancy Support Counselling Service items, with a focus on expanding eligibility and increasing the number of sessions to be inclusive of diverse parents and families and better meet the ongoing psychological support needs of significant others impacted by stillbirth.*

Enhance specialist communication training for health professionals working with families affected by perinatal loss

Given the importance of doctor-patient communication in health outcomes[35], and the specific need of parents to have their loss acknowledged by their health care provider[31], the nature of health professional communications is a critical component of stillbirth care. Despite the emphasis on communication and empathy in medical and clinician training, research indicates that graduates often adapt to workplace environments where these skills are not consistently modelled or reinforced[36].

Health professional communications and investigations that take place as a result of stillbirth are occurring during a very acute time of loss for parent/s, family and kin and are by nature emotional, distressing and potentially psychologically damaging[22]. While timely communication and investigation processes are important, it must not come at the expense of sensitivity or emotional awareness. Healthcare providers must communicate in compassionate and sensitive ways that aim to ease—rather than compound—grief by approaching all discussions, including those regarding investigations, with a person-centred and trauma-informed lens[13,31,37].

It is important for healthcare providers to be able to openly discuss the isolation and stigma that may be associated with stillbirth and acknowledge and address any feelings of shame or guilt that the affected families may experience[10]. Not addressing these very common reactions risks not acknowledging and validating their experience which has been identified as an important need by patients[31].

The Sands Australian Principles of Bereavement Care[28] note the need to provide specific training for all staff working with stillbirth loss:

> *"Principle I: Health Professionals Trained in Bereavement Care All health professionals who interact with bereaved parents should be aware of the Sands Australian Principles and should aim to attend professional development opportunities on bereavement care to ensure that the goal of consistent bereavement care across Australia is achieved"* (p. 16).

A commitment to safe, high-quality person-centred bereavement care and support for pregnancy loss and stillbirth, therefore, requires healthcare services to ensure all health professionals are trained to provide information with compassion, appropriately acknowledge and support grief responses and the impacts of social stigma and provide for physical and psychological needs in culturally safe, trauma-informed ways[21,38]

Incorporating clinician wellbeing within training and ensuring access to peer support, supervision, debriefing and staff psychological support services reduces burnout and compassion fatigue. Training should also be extended to operational staff (e.g., food services, cleaners) who also routinely come into contact with bereaved parents, and often at times when other formal and informal supports may not be present[18].

Recommendation 4.

The APS is well positioned to collaborate with the South Australian Government, Health Department, people with lived experience, and other stakeholders to enhance existing communication training programs or develop new trauma-informed communication training programs for health professionals supporting people affected by perinatal loss, including stillbirth.

3. Data, Research and System Monitoring

Relevant Inquiry Terms of Reference

e) processes of data collection, reporting and monitoring;
f) allocation of research effort; and
g) any other related matters.

Data collection, reporting, and research allocation are critical to improving stillbirth prevention, care, and bereavement support[12,13]. Comprehensive and standardised data collection ensures a better understanding of risk factors, service gaps and the effectiveness of interventions. Transparent reporting and monitoring help identify trends, inform evidence-based policy decisions and drive continuous improvements in care. Additionally, prioritising research and evaluation efforts towards improving the safety and efficacy of prevention and intervention strategies, particularly for diverse and priority populations is essential to addressing disparities and improving outcomes for all people, families, kin and communities affected by stillbirth[39,40].

Recommendation 5.

The APS recommends that the South Australian Government strengthen data collection, reporting, and monitoring processes to enhance understanding of stillbirth and bereavement care needs. Further, dedicated evaluation funding should prioritise data collection, reporting and monitoring of psychosocial risk factors associated with stillbirth and the effectiveness of psychologicall interventions to ensure that bereaved families receive appropriate, best-practice care and support.

Recommendation 6.

The APS recommends that the South Australian Government provided dedicated funding for interdisciplinary research that prioritises psychological care including effective prevention and bereavement care. Additionally, research priorities and designs should be co-designed with bereaved parents and others with lived experience of stillbirth, ensuring that psychological interventions address real-world needs and experiences.

Stillbirth has a profound and lasting impact on parents, families, kin and communities, often leading to long-term grief and psychological challenges with far-reaching impacts. Effective prevention, early intervention and bereavement support require evidence-based services that are accessible, trauma-informed and culturally safe. By routinely integrating psychologists into multidisciplinary care teams, strengthening funding for psychological initiatives, and expanding research into psychological care, South Australia can enhance support for bereaved families and contribute to reducing stillbirth rates.

To ensure a coordinated and effective response, South Australian Government strategies and initiatives for stillbirth prevention and bereavement care should align with broader perinatal and mental health policies, fostering consistency across Australian jurisdictions.

The APS acknowledges the SA Government's commitment to addressing this critical issue and welcomes the opportunity to contribute to this Inquiry. We stand ready to collaborate on implementing inquiry recommendations to ensure that psychological science underpins best practice in stillbirth prevention, intervention and bereavement care.

References

1. United Nations Office of the High Commissioner. (2023). *The core international human rights instruments and their monitoring bodies*. https://www.ohchr.org/en/core-international-human-rights-instruments-and-their-monitoring-bodies
2. United Nations, Department of Economic and Social Affairs. (2023). *Sustainable development goals*. https://sdgs.un.org/goals
3. De Neve, J.-E., & Sachs, J. D. (2020). Sustainable development and human well-being. *World Happiness Report*, 112–127.
4. Dolman, C., Jones, I. R., & Howard, L. M. (2016). Women with bipolar disorder and pregnancy: Factors influencing their decision-making. *BJPsych Open*, *2*(5), 294–300. https://doi.org/10.1192/bjpo.bp.116.003079
5. Catalao, R., Mann, S., Wilson, C., & Howard, L. M. (2020). Preconception care in mental health services: Planning for a better future. *The British Journal of Psychiatry*, *216*(4), 180–181. https://doi.org/10.1192/bjp.2019.209
6. Brockington, I. F., Macdonald, E., & Wainscott, G. (2006). Anxiety, obsessions and morbid preoccupations in pregnancy and the puerperium. *Archives of Women's Mental Health*, *9*(5), 253–263. https://doi.org/10.1007/s00737-006-0134-z
7. Fairbrother, N., Collardeau, F., Albert, A. Y. K., Challacombe, F. L., Thordarson, D. S., Woody, S. R., & Janssen, P. A. (2021). High prevalence and incidence of obsessive-compulsive disorder among women across pregnancy and the postpartum. *The Journal of Clinical Psychiatry*, *82*(2), 30368. https://doi.org/10.4088/JCP.20m13398
8. Westby, C. L., Erlandsen, A. R., Nilsen, S. A., Visted, E., & Thimm, J. C. (2021). Depression, anxiety, PTSD, and OCD after stillbirth: A systematic review. *BMC Pregnancy and Childbirth*, *21*(1), 782. https://doi.org/10.1186/s12884-021-04254-x
9. Burden, C., Bradley, S., Storey, C., Ellis, A., Heazell, A. E. P., Downe, S., Cacciatore, J., & Siassakos, D. (2016). From grief, guilt pain and stigma to hope and pride – a systematic review and meta-analysis of mixed-method research of the psychosocial impact of stillbirth. *BMC Pregnancy and Childbirth*, *16*(1), 9. https://doi.org/10.1186/s12884-016-0800-8
10. Pollock, D., Pearson, E., Cooper, M., Ziaian, T., Foord, C., & Warland, J. (2021). Breaking the silence: Determining prevalence and understanding stillbirth stigma. *Midwifery*, *93*, 102884. https://doi.org/10.1016/j.midw.2020.102884
11. Due, C., Lockton, J., & Oxlad, M. (2019). *When a baby is stillborn, grandparents are hit with "two lots of grief". Here's how we can help*. The Conversation. http://theconversation.com/when-a-baby-is-stillborn-grandparents-are-hit-with-two-lots-of-grief-heres-how-we-can-help-122313
12. Australian Government Department of Health and Aged Care. (2021, March 19). *National Stillbirth Action and Implementation Plan*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan?language=en
13. Australian Commission on Safety and Quality in Health Care (ACSQHC). (2022, November). *Stillbirth Clinical Standard*. ACSQHC. https://www.safetyandquality.gov.au/standards/clinical-care-standards/stillbirth-clinical-care-standard
14. Stillbirth Centre of Research Excellence. (n.d.). *Safer Baby Bundle*. https://stillbirthcre.org.au/projects/the-safer-baby-bundle-national-rollout/
15. Tsirtsakis, A. (2020). *Hundreds of stillbirths preventable with improved maternity care: Research*. NewsGP. https://www1.racgp.org.au/newsgp/clinical/hundreds-of-stillbirths-preventable-with-improved
16. Headley, E., Gordon, A., & Jeffery, H. (2009). Reclassification of unexplained stillbirths using clinical practice guidelines. *The Australian & New Zealand Journal of Obstetrics & Gynaecology*, *49*(3), 285–289. https://doi.org/10.1111/j.1479-828X.2009.00989.x
17. Centre of Perinatal Excellence. (2022). Coping After a Stillbirth. *COPE*. https://www.cope.org.au/planning-a-family/pregnancy-loss/coping-stillbirth/

18. Lyons, A. (2019). *Removing stigma around stillbirth: 'The time is now.'* NewsGP. https://www1.racgp.org.au/newsgp/clinical/removing-stigma-and-increasing-awareness-around-st
19. Chan, L., Owen, K. B., Andrews, C. J., Bauman, A., Brezler, L., Ludski, K., Mead, J., Birkner, K., Vatsayan, A., Flenady, V. J., & Gordon, A. (2023). Evaluating the reach and impact of Still Six Lives: A national stillbirth public awareness campaign in Australia. *Women and Birth*, *36*(5), 446–453. https://doi.org/10.1016/j.wombi.2023.02.006
20. Australian Government Department of Health and Aged Care. (n.d.). *Medicare Benefits Schedule, Item 4001, Pregnncy Support Counselling*. Retrieved January 30, 2025, from https://www9.health.gov.au/mbs/fullDisplay.cfm?q=4001
21. Shakespeare, C., Merriel, A., Bakhbakhi, D., Blencowe, H., Boyle, F. M., Flenady, V., Gold, K., Horey, D., Lynch, M., & Mills, T. A. (2020). The RESPECT Study for consensus on global bereavement care after stillbirth. *International Journal of Gynecology & Obstetrics*, *149*(2), 137–147. https://doi.org/10.1002/ijgo.13110
22. Heazell, A. E., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., Dang, N., Das, J., Flenady, V., & Gold, K. J. (2016). Stillbirths: Economic and psychosocial consequences. *The Lancet*, *387*(10018), 604–616. https://doi.org/10.1016/S0140-6736(15)00836-3
23. Flenady, V., Wojcieszek, A., Ellwood, D., Boyle, F., Morris, J., & Middleton, P. (2017). *Five ways to help parents cope with the trauma of stillbirth*. The Conversation. http://theconversation.com/five-ways-to-help-parents-cope-with-the-trauma-of-stillbirth-69622
24. Child Bereavement UK. (2018). *When your baby dies*. Child Bereavement UK. https://www.childbereavementuk.org/when-your-baby-dies
25. Flenady, V., Wojcieszek, A. M., Middleton, P., Ellwood, D., Erwich, J. J., Coory, M., Khong, T. Y., Silver, R. M., Smith, G. C. S., Boyle, F. M., Lawn, J. E., Blencowe, H., Leisher, S. H., Gross, M. M., Horey, D., Farrales, L., Bloomfield, F., McCowan, L., Brown, S. J., … Reddy, U. (2016). Stillbirths: Recall to action in high-income countries. *The Lancet*, *387*(10019), 691–702. https://doi.org/10.1016/S0140-6736(15)01020-X
26. Obst, K. L., Oxlad, M., Due, C., & Middleton, P. (2021). Factors contributing to men's grief following pregnancy loss and neonatal death: Further development of an emerging model in an Australian sample. *BMC Pregnancy and Childbirth*, *21*(1), 1–16. https://doi.org/10.1186/s12884-020-03514-6
27. Allen, K. R., & Craven, C. C. (2020). Losing a child: Death and hidden losses in LGBTQ-parent families. In *LGBTQ-Parent Families* (pp. 349–362). Springer.
28. Sands, & Stillbirth CRE. (n.d.). *Sands Australian Principles of Bereavement Care*. https://www.sands.org.au/Handlers/Download.ashx?IDMF=72d72a34-ed78-41af-8196-505cdd70740c
29. Shreffler, K. M., Hill, P. W., & Cacciatore, J. (2012). Exploring the increased odds of divorce following miscarriage or stillbirth. *Journal of Divorce & Remarriage*, *53*(2), 91–107. https://doi.org/10.1080/10502556.2012.651963
30. Murphy, S., & Cacciatore, J. (2017). The psychological, social, and economic impact of stillbirth on families. *Seminars in Fetal and Neonatal Medicine*, *22*(3), 129–134.
31. Peters, M. D., Lisy, K., Riitano, D., Jordan, Z., & Aromataris, E. (2015). Caring for families experiencing stillbirth: Evidence-based guidance for maternity care providers. *Women and Birth*, *28*(4), 272–278. https://doi.org/10.1016/j.wombi.2015.07.003
32. Kcomt, L., Gorey, K. M., Barrett, B. J., & McCabe, S. E. (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM - Population Health*, *11*, 100608. https://doi.org/10.1016/j.ssmph.2020.100608
33. Callander, E., Fox, H., Mills, K., Stuart-Butler, D., Middleton, P., Ellwood, D., Thomas, J., & Flenady, V. (2021). Inequitable use of health services for Indigenous mothers who experience stillbirth in Australia. *Birth*.

34. Saxby, K., New, S. C. de, & Petrie, D. (2020). Structural stigma and sexual orientation disparities in healthcare use: Evidence from Australian Census-linked-administrative data. *Social Science & Medicine*, *255*, 113027. https://doi.org/10.1016/j.socscimed.2020.113027
35. Ha, J. F., & Longnecker, N. (2010). Doctor-Patient Communication: A Review. *The Ochsner Journal*, *10*(1), 38–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/
36. Bombeke, K., Symons, L., Debaene, L., De Winter, B., Schol, S., & Van Royen, P. (2010). Help, I'm losing patient-centredness! Experiences of medical students and their teachers. *Medical Education*, *44*(7), 662–673. https://doi.org/10.1111/j.1365-2923.2010.03627.x
37. Gilligan, C., & Leopardi, E. (2021). *Doctors are trained to be kind and empathetic – but a "hidden curriculum" makes them forget on the job*. The Conversation. http://theconversation.com/doctors-are-trained-to-be-kind-and-empathetic-but-a-hidden-curriculum-makes-them-forget-on-the-job-171942
38. Chow, A. Y. M. (2021). Bereavement Care. In D. Gu & M. E. Dupre (Eds.), *Encyclopedia of Gerontology and Population Aging* (pp. 643–648). Springer International Publishing. https://doi.org/10.1007/978-3-030-22009-9_1007
39. Hickey, S., Roe, Y., Gao, Y., Nelson, C., Carson, A., Currie, J., Reynolds, M., Wilson, K., Kruske, S., Blackman, R., Passey, M., Clifford, A., Tracy, S., West, R., Williamson, D., Kosiak, M., Watego, S., Webster, J., & Kildea, S. (2018). The Indigenous Birthing in an Urban Setting study: The IBUS study. *BMC Pregnancy and Childbirth*, *18*(1), 431. https://doi.org/10.1186/s12884-018-2067-8
40. Kilcullen, M., Kandasamy, Y., Watson, D., & Cadet-James, Y. (2021). Stillbirth risks and rates for Aboriginal and Torres Strait Islander women and their babies in North Queensland. *Australian and New Zealand Journal of Obstetrics and Gynaecology*.