

**Liability in Negligence of Clergy and Churches in New South Wales for Pastoral  
Counselling for Depression**

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**Master of Laws By Thesis**

**2005**

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## **CERTIFICATE OF AUTHORSHIP / ORIGINALITY**

I certify that the work in this thesis has not been submitted for a degree nor has it been submitted as part of the requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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William Geoffrey Spaul

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## ABSTRACT

The thesis suggests an approach to be taken in determining whether clergy who provide pastoral counselling for depression<sup>1</sup> to individuals in New South Wales owe a duty of care.<sup>2</sup> The ‘pastoral’ nature of pastoral counselling for depression is defined herein by reference to several indicia, including that the cleric is a non-professional counsellor and that the counselling is wholly or primarily based on religion.<sup>3</sup>

The *Civil Liability Amendment (Personal Responsibility) Act 2002* (NSW) (‘the *CLA*’) does not provide a general statement of when a duty of care arises. The common law continues to apply, to the extent not supplanted by the *CLA*. Whatever the *CLA*’s overall effect, the change to the law has not been extensive as it may relate to the existence of the postulated duty of care.<sup>4</sup>

There is no Australian case of direct relevance to pastoral counselling for depression, and no majority accepted general approach in the High Court of Australia (‘the Court’) for determining whether a duty of care exists. It is contended that whether a duty of care will arise for pastoral counselling for depression by clergy may appropriately be determined by reference to the following questions, to be answered with regard to the facts of the case.

These are whether the cleric knew, or a reasonable cleric would have known, of a likelihood of a client relying on the counselling; whether such reliance would be reasonable; whether pastoral counselling for depression could increase the client’s vulnerability if reasonable care is not taken; whether harm to the client is foreseeable to a reasonable cleric as a result of an act or omission when providing pastoral counselling for depression; whether it would be unreasonable, having regard to the public interest, for the cleric to be subject to a duty of care; and whether imposing a duty of care would subject clergy or churches to an unreasonable burden.

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<sup>1</sup> ‘Depression’ and ‘pastoral counselling for depression’ are defined in chapters three and four respectively.

<sup>2</sup> In relation to harm other than pure mental harm. Mental harm consequent upon other personal injury is dealt with in section 17.10. Pure mental harm is mental harm not consequent upon other person injury - section 27 of the *CLA*. Pure mental harm is dealt with in Appendix A.

<sup>3</sup> The terms ‘non-professional counsellor’ and ‘religion’ are defined in the Definitions section.

<sup>4</sup> The main changes of relevance have been in relation to the test for reasonable foreseeability - see chapter eleven and Appendix A. The provision of the *CLA* protecting ‘good samaritans’ from civil liability may also apply, but only for counselling performed in emergency situations - see section 5.3.

Affirmative answers to each of the first four questions and a negative answer to the fifth and sixth questions in a particular case would result in a finding that a duty of care existed. A negative answer to any of the first four questions or an affirmative answer to either of the fifth and sixth questions would mean no duty of care.

It is argued that the provisions of the *CLA* about the standard of care for professionals do not apply to pastoral counselling for depression, and the cleric must act as a reasonable cleric who provides pastoral counselling for depression should in the circumstances. Referral of the client to a general medical practitioner or mental health professional ('the duty to refer') is the main constituent of the degree of care required, if a duty of care arises.

As it relates to causation, the *CLA* was intended by parliament to guide courts as they apply the common sense approach developed by the Court. Whether breach of the duty to refer may be the cause of a suicide attempt by a client, and therefore of damage resulting from the attempt, is considered.<sup>5</sup> It is argued that in some circumstances it may, and that a suicide attempt does not in itself break the causal chain.

The law and main issues relevant to whether a church could be liable for a cleric's counselling negligence are also identified.

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<sup>5</sup> Damage which might occur in the absence of a suicide attempt, whether from breach of the duty to refer or some other breach of duty, is noted in Appendix A.

## PREFACE

The thesis is a Master's thesis, not one supporting a submission for a Doctorate of Philosophy. The thesis takes account of law of significant relevance to its aims to 31 March 2005.

Chapter one provides a description of the areas addressed by the thesis. Some of the areas which the thesis does not concern are now identified.

### **The thesis does not concern all forms of counselling by clergy**

The thesis does not concern pastoral counselling in general, or all forms of counselling for depression which clergy might provide, but rather 'pastoral counselling for depression', defined in chapter four.

While there is a paucity of empirical data as to the counselling practices of Australian clergy, it seems likely that this is not a typical pastoral counselling situation, just as the landmark Californian case of *Nally v Grace Community Church of the Valley*<sup>6</sup> ('Nally'), to which further reference will be made,<sup>7</sup> did not involve a typical pastoral counselling situation. As counsel for the plaintiffs in that case argued:

We are talking about a very unusual fact situation that produced tragic, terrible and not so unusual results. We are not talking about typical pastoral counseling or typical religious counseling ... We are concerned with a situation which we believe is very rare. This is a situation where some men, under the guise, and by guise I do not mean to suggest that they were insincere, but under the roof of the church ... take on the horrendous task of providing the ... treatment and ... care of the severely mentally ill. That is not your typical religious counseling.<sup>8</sup>

The situation may not be commonplace, but it warrants investigation nonetheless.

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<sup>6</sup>204 Cal. Rptr.303 (Cal. App. 2 Dist. 1984) (Californian Court of Appeal); 240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987) (Californian Court of Appeal); 253 Cal. Rptr 97 (Cal. 1988) (Californian Supreme Court); certiorari denied 490 US 1007 (1989) (US Supreme Court).

<sup>7</sup> See in particular section 1.1 and chapter two.

<sup>8</sup> Edward Barker, argument to the Californian Supreme Court, quoted in Weitz. M.A. 2001, *Clergy Malpractice in America: Nally v Grace Community Church of the Valley*, University Press of Kansas, 169-170. This book is primarily a historical account of *Nally* written for a general audience.

## **The thesis does not concern a possible duty of care to people other than clients**

For the purposes of the thesis, a client is defined as a person aged eighteen or over to whom a cleric provides pastoral counselling for depression.<sup>9</sup>

The consequences of a breach of duty where counselling for depression is provided may include damage arising from a suicide attempt. Obviously, where a suicide attempt results in death, only certain persons apart from the client would have a possibility of bringing a successful action. Consideration of such actions and the eligibility of particular relatives and people to bring them has limited, if any, connection to the main subject matter of the thesis, and is beyond the scope of the thesis. The same applies in relation to the rights, if any, of those exposed to the possibly distressing aftermath of an unsuccessful suicide attempt.

Whether a cleric has a duty to take measures to reduce the risk of a potentially dangerous client harming a third party is also beyond the scope of the thesis.

## **The thesis is not about a duty of care in relation to pure mental harm**

The *CLA* varies the test for reasonable foreseeability in relation to harm other than mental harm.<sup>10</sup> It also imposes a separate foreseeability test in relation to duty of care and mental harm.<sup>11</sup> The circumstances to be considered in applying this separate test differ according to whether the mental harm is 'pure mental harm', defined by the *CLA* as mental harm not consequent upon other personal injury,<sup>12</sup> or mental harm that is consequent upon other personal injury.<sup>13</sup>

Comprehensive consideration of the duty of care issue in relation to pure mental harm would take the thesis well beyond its intended scope and is not possible within space limitations. Some discussion of the issue has been included in Appendix A.

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<sup>9</sup> See the Definitions section.

<sup>10</sup> Section 5B (1) (b). See further section 11.1.

<sup>11</sup> Section 32(1). See further Appendix A.

<sup>12</sup> Section 27. See further Appendix A.

<sup>13</sup> See sections 32 (2) and 32 (3). See further section 17.10 and Appendix A.

Moreover, it has recently been stated that there is an ‘element of guesswork’ as to the meaning of some of the provisions of the *CLA*:

Few court decisions have yet arisen other than on damages assessment ... and there is an element of guesswork as to the meaning and effect of some of the legislative changes.<sup>14</sup>

This applies to the meaning of the terms ‘recognised psychiatric illness’ and ‘normal fortitude’ for the purposes of foreseeability test imposed stated by section 32 of the *CLA*. Hence it would be of limited utility to consider the issue of liability for pure mental harm resulting from pastoral counselling for depression beyond the observations which are made in Appendix A.

The thesis therefore focusses on harm consisting of physical injury and harm which is consequent to that injury. In the context of pastoral counselling for depression, physical injury will pre-eminently occur from a suicide attempt. As will be seen, the duty to refer is the main constituent of the degree of care required of clergy where they provide pastoral counselling for depression. It is thus fitting for the thesis to focus, in relation to causation and damage, on whether breach of the duty to refer may be the cause of a suicide attempt. This point is taken up in section 1.3.

The possibility of a plaintiff obtaining damages for mental harm consequent upon physical injury is noted in section 17.10. This potential, however, is also contingent on the meaning of ‘recognised psychiatric illness’ and ‘normal fortitude’, thus definitive comment on the issue is unattainable. The possibility of other modes of damage from other breaches of duty is noted in Appendix A.

### **The thesis does not address the possible obligations of non-Christian clergy, or of clergy who are professional counsellors**

The definition of clergy is limited to Christian clergy.<sup>15</sup> It is well-known that Christianity is the main religion in Australia. No attempt is made to consider the ways, if any, the possible legal obligations of clergy from non-Christian religions may vary according to religious differences. While some clergy may be ‘professional counsellors’,<sup>16</sup> the obligations of such clergy are beyond the scope of the thesis.

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<sup>14</sup>Dietrich, J. ‘Duty of Care under the ‘Civil Liability Acts’’ (2005) 13 *Torts Law Journal*, 17, 18.

<sup>15</sup>See the Definitions section.

<sup>16</sup>This term is defined in the Definitions section.

## **Other limitations to the scope**

The thesis does not aim to criticise clergy, or to comprehensively state the law of negligence. It does not seek to examine every conceivable legal issue connected to provision of counselling for depression by clergy. Neither does it examine church law;<sup>17</sup> whether churches or clergy owe fiduciary duties to clients of clergy;<sup>18</sup> whether the relationship of clergy and clients is contractual;<sup>19</sup> the liability of non-ordained personnel at church-related counselling centres or of lay people associated with churches; sex crimes or misconduct by clergy; or whether clergy who provide counselling for depression should be accredited or registered.

Unlike psychologists, counsellors in Australia are not required by law to be registered. The Psychotherapy and Counselling Federation of Australia maintains a register of counsellors who are members of relevant professional associations and have completed courses giving them a certain minimum level of competence.<sup>20</sup>

In Australia ‘there have been isolated efforts over a number of years to create an environment where Christian counselling can be recognised as having nationally agreed standards of training’.<sup>21</sup> It remains to be seen whether the legislature will require the registration of counsellors, or of clergy who provide counselling.

## **Applicability of the thesis to different denominations**

It is necessary to draw a distinction between clergy who provide counselling and those who do not. The thesis obviously does not apply to situations where clergy do not counsel for depression.

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<sup>17</sup> Civil courts will not enforce *church* law unless proprietary rights are involved: eg. *Scandrett v Dowling* (1992) 27 NSWLR 483 per Priestley JA at 565 (Hope AJA agreeing); *Ermogenous v Greek Orthodox Church of SA Inc* (2002) 76 ALJR 465 per Kirby J at 479. The *common law* will be enforced regardless of whether the issues involve property - see further section 5.10 (final paragraph).

<sup>18</sup> The High Court held in *Breen v Williams* (1996) 186 CLR 71 that doctors do not generally owe fiduciary duties to patients. Whether this is relevant to clergy is not pursued herein.

<sup>19</sup> See further section 5.7.

<sup>20</sup> Conversation by the author with Mr Ron Perry, Vice-President of the Psychotherapy and Counselling Federation of Australia 30.07.02.

<sup>21</sup> Court, J.H. ‘Church Related Counseling in Australia’ (1997) 16 *Journal of Psychology and Christianity* 142, 146.

It has been suggested that some clergy in Australia provide counselling because they are seen as ‘gifted’ or merely available, while not being aware of their limitations.<sup>22</sup>

Empirical data concerning the numbers of clergy in Australia providing counselling or the denominations to which they might belong is unavailable. There is some anecdotal evidence that in general in Australia, clergy from Pentacostal denominations are more likely to engage in counselling. Pentacostalism:

[H]as emerged as one of the most vigorous religious movements in Australia. Pentacostalism is the faith of a number of churches such as the Assemblies of God, Apostolic Church ... Full Gospel churches, Christian Outreach Centre, Christian Life Centre and others.<sup>23</sup>

Pentacostal churches differ to some extent from the churches of other denominations:

The most distinctive feature of Pentacostalists is their mode of worship, which includes praying with the hands outstretched, dancing, speaking in tongues, faith healing, cheery singing and other exuberant practices led by a preacher. They are anti-intellectual to the extent that they stress inherent spiritual authority rather than mastery of theology or any formal ritual.<sup>24</sup>

It is unclear whether ‘inherent spiritual authority’ might influence the counselling practices of any pentacostal clergy who undertake counselling for depression. As will be seen in chapters one and two, the defendant pastors in *Nally* relied heavily on religious ideas and the Bible in their counselling activities.

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<sup>22</sup>Court, 143-146

<sup>23</sup>Carey, H.M. 1996 *Believing in Australia: A Cultural History of Religions*, Allen & Unwin, Sydney, 173.

<sup>24</sup>*Ibid* 188.

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- Bennett v Minister of Community Welfare* (1992) 176 CLR 408
- Betts v Whittingslowe* (1945) 71 CLR 637
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- Breen v Williams* (1996) 186 CLR 71
- Brodie v Singleton Shire Council* (2001) 75 ALJR 992
- Bryan v Moloney* (1995) 182 CLR 609
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*Kondis v STA* (1984) 154 CLR 672  
*Kruger v The Commonwealth* (1996) 190 CLR 1  
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*O'Shea v Sullivan & Anor* (1994) ATR 81-273

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*Parramatta City Council v Lutz* (1988) 12 NSWLR 293

*Perre v Apand* (1999) 198 CLR 180

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*Rosenberg v Percival* (2001) 75 ALJR 734

*San Sebastian Pty Ltd v The Minister* (1986) 162 CLR 340

*Scandrett v Dowling* (1992) 27 NSWLR 483.

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*Scott v Davis* (2000) 204 CLR 333

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*Sutherland Shire Council v Heyman* (1985) 157 CLR 424  
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*Woods v Multi-Sport Holdings Pty Ltd* (2002) 76 ALJR 483  
*Woolcock Street Investments Pty Ltd v CDG Pty Ltd* (2003) 216 CLR 515.  
*Wyong Shire Council v Shirt* (1980) 146 CLR 40  
*Zuijs v Wirth Brothers Pty Ltd* (1955) 93 CLR 561

## TABLE OF LEGISLATION

*Anglican Church of Australia Trust Property Act 1917* (NSW)

*Baptist Churches of New South Wales Property Trust Act 1984* (NSW)

*Civil Liability Amendment (Personal Responsibility) Act 2002* (NSW)

*Health Care Liability Act 2001* (NSW)

*Interpretation Act 1987* (NSW)

*Law Reform (Vicarious Liability) Act 1983* (NSW)

*Legal Profession Act 1987* (NSW)

*Lutheran Church of Australia (New South Wales District) Property Trust Act 1982* (NSW)

*Mental Health Act 1990* (NSW)

*Presbyterian Church (Corporations) Act 1995* (NSW)

*Psychological Practices Act 1965* (Vic)

*Psychologists Act 1989* (NSW)

*Psychologists Act 2001* (NSW)

*Uniting Church in Australia Act 1977* (NSW).

## Definitions

A **‘church’** is essentially a voluntary association of individuals holding property for religious and therefore charitable purposes.<sup>25</sup> This definition suffices for the general purposes of the thesis. Ambiguities in the term ‘church’ are noted in chapter nineteen.

**‘The CLA’** means the *Civil Liability Amendment (Personal Responsibility Act) 2002* (NSW).

**‘Clergy’** is the plural of cleric. For the purposes of the thesis, cleric means a person appointed, ordained, licensed or otherwise authoritatively empowered by a church for religious service, and who, if engaged in the provision of counselling at all, is a ‘non-professional counsellor’, as that term is defined herein. ‘Clergy’ will be used as a synonym for ‘preachers’, ‘ministers’, ‘pastors’, ‘reverends’, ‘priests’ and similar titles. This definition is limited to Christian clergy.

**‘Client’** for the purposes of the thesis means a person aged eighteen and over who receives pastoral counselling for depression by a cleric. This is for identification purposes only and does not signify a relationship warranting a duty of care or a particular degree of care.

**‘Counselling’** is a notoriously ambiguous term and is often used interchangeably with ‘psychotherapy’.<sup>26</sup> The primary term used by the thesis is ‘pastoral counselling for depression’, not counselling. For the purposes of the thesis ‘counselling’ means communication between a counsellor and another person, occurring during one or more scheduled sessions, with the purpose of solving one or more of the other person’s problems, through the provision of advice or information or in some other way involving verbal communication. Counselling is sometimes defined as a professional activity,<sup>27</sup> but in reality is not an exclusively professional activity.<sup>28</sup>

**‘Counsellor’** means for the purposes of the thesis a ‘professional counsellor’ or ‘non-professional counsellor’ as those terms are defined herein. The thesis concerns the potential liability of clergy who provide pastoral counselling for depression, not the liability of other personnel for other communication.

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<sup>25</sup> McPherson, Hon. Mr Justice B.H. ‘The Church as Consensual Compact, Trust and Corporation’ (2000) 74 *ALJ* 159, 160.

<sup>26</sup> See chapter four.

<sup>27</sup> See section 4.1.

<sup>28</sup> There is no requirement in New South Wales that those who engage in counselling be trained in counselling - see section 5.5.

‘**The Court**’ means the High Court of Australia.

‘**Degree of care**’ will refer to the measures which reasonable care requires, where a duty of care exists. Degree of care may be viewed as synonymous with terminology such as ‘scope of duty’, ‘measure of duty’, ‘extent of the duty’, and ‘content of the duty’, about which there is no consistent judicial practice.

‘**Depression**’ means in the thesis major depressive disorder and bipolar disorder as defined in chapter three.

The ‘**duty to refer**’ will denote in the thesis one of the measures which the overall degree of care might require, where a duty of care exists. This method of expression has been disapproved by one text book, but is not uncommon:

It is not uncommon to encounter formulations of the standard [degree] of care in terms of “duty”, as when it is asserted that a motorist is under a duty to keep a proper lookout ... But this method of expression is best avoided ....<sup>29</sup>

Referring to ‘the duty to refer’ is more compendious than ‘the obligation to refer’ or ‘the requirement to refer’. With this in mind, it should be readily understood that such terminology pertains to the issue of degree of care, not duty of care.

‘**General practitioner**’ means a general medical practitioner in the thesis.

‘**Informal pastoral counselling for depression**’ is defined in section 4.6.

‘**Malpractice**’ is a term used more in the United States than Australia, and is not used by the thesis. Where it appears in material which is quoted, it may be viewed as interchangeable with ‘negligence’.

‘**Mental health professional**’ will refer to psychiatrists, psychologists and other practitioners in the mental health field who have completed university level degrees or training in psychiatry, psychology, psychotherapy or counselling.

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<sup>29</sup> Fleming, J.G. 1998 *The Law of Torts* 9th edn LBC Information Services Sydney, 117.

**‘Non-professional counsellor’** means in the thesis a person who provides counselling on a casual or irregular basis only, and who does not possess secular qualifications, training or competence in counselling, psychotherapy, psychology, psychiatry, medicine or the management of depression or other mental or emotional problem.

The **‘objective of spiritual welfare’** is for the purposes of the thesis defined as the objective of increasing the client’s religious knowledge or belief, or increasing the client’s compliance with canons of conduct giving effect to religious belief.

**‘Pastoral care’** is defined in section 4.2.

**‘Pastoral counselling’** and **‘pastoral counselling for depression’** are defined in sections 4.3 and 4.4 respectively. The thesis is not about pastoral counselling in general, or all forms of counselling for depression that clergy might provide.

**‘Professional counsellor’** means herein a person who provides counselling on a regular basis and who possesses secular qualifications, training or competence in counselling, psychotherapy, psychology, psychiatry, medicine or the management of depression.

The definition of ‘professional’ is a matter about which ‘no agreement is possible’, and ‘those occupations claiming its mantle would lead one to the conclusion that it was expandable to subsume any known occupation’.<sup>30</sup> The definition of professional counsellor adopted herein is broadly consistent with the definition of ‘professional’ proffered by Santow J in a trade practices case:

[R]eferences to profession and professional activity at least include ... medicine, dentistry and the law ... They may ... include, for example taxation consultants, brokers, teachers and conceivably ... mediators. One might distinguish mediation done casually and as an adjunct to another activity, such as a Minister of Religion or Rabbi and mediation done as a principal activity by a trained mediator suitably accredited. Thus the same activity carried on in an untrained or ad hoc way lacking any accreditation, code of ethics or special competence and training would fall outside the notions of profession and professional activity.<sup>31</sup>

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<sup>30</sup> Partlett, D.F. 1985 *Professional Negligence* The Law Book Company Limited, Sydney, 2. In England it has been said that ‘professional’ is ‘an ill-defined term’ - Davies, M, ‘Debt Counselling: the rise of a new profession and the professional negligence implications’ (1995) 11 *Professional Negligence* 27, 28-29. Whether clergy are professionals is a matter of conjecture. Of background interest is the fact that in the US it has been said that clergy have been ‘established as professionals since the middle ages’ - Wilensky, H. ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137, 141, and that ‘pastoral counselling [is an] established profession in the psychotherapy field’ - Robertson, J.D. 1988 *Psychiatric Malpractice: Liability of Mental Health Professionals* John Wiley & Sons New York, 428.

<sup>31</sup> *Prestia v Aknar* (1986) 40 NSWLR 165 per Santow J at 189.

According to the Royal Australian and New Zealand College of Psychiatrists, a '**psychiatrist**' is a 'medical specialist who has completed at least 13 years of medical education in all aspects of medicine, surgery and psychiatry. Psychiatrists have a unique perspective in being able to diagnose, manage and care for people with mental illnesses and emotional problems whilst keeping both their emotional and physical states in perspective. In addition, psychiatrists are able to offer expert psychological and medical help in the balance required for the individual patient'.<sup>32</sup>

'**Psychiatry**' is the branch of medicine that deals with the diagnosis, treatment and prevention of mental and emotional disorders.

'**Psychologists**' cannot practise in New South Wales unless they satisfy section 8 of the *Psychologists Act 2001* which requires 4 years of full-time study in psychology at an approved university or institution or have passed an examination approved by the Psychologist Registration Board, and 2 years of practical experience or 2 years of postgraduate study equivalent to 2 years of practice experience in psychology.

'**Psychology**' means herein the science that deals with mental processes and behaviour, or the application of ideas derived from this science to the treatment of mental or emotional disorders or issues.

There are a large number of definitions of '**psychotherapy**', which is often used interchangeably with counselling. The term is sometimes prefixed by words such as 'medical', 'clinical' or 'specialised'. The Royal Australian and New Zealand College of Psychiatrists describes it simply as 'talking treatment'.<sup>33</sup> The definition of psychotherapy is not of critical importance to the thesis, as the thesis concerns 'pastoral counselling for depression'. For the purposes of the thesis the term means the treatment by verbal communication of mental or emotional disorders or problems.

A '**reasonable cleric**' means in the thesis a reasonable person in the position of a cleric who provides pastoral counselling for depression.

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<sup>32</sup> [www.ranzcp.org](http://www.ranzcp.org).

<sup>33</sup> [www.ranzcp.org](http://www.ranzcp.org).

The definition of ‘**religion**’ has received consideration by the Court in only two cases, namely *Adelaide Company of Jehovah’s Witnesses v Commonwealth*<sup>34</sup> and *Church of the New Faith v Commissioner of Payroll Tax (Vic)*<sup>35</sup> (*Scientology*). In *Jehovah’s Witnesses*, consistent with his view that it was inappropriate for the Court to define religion,<sup>36</sup> Latham CJ did not place any limitation on the concept of religion:

One of the chief religions of the world, Buddhism, has risen to great moral and intellectual heights without using the conception of God at all; in its stead it has Dharma, the eternal law ... On the other hand, almost any matter may become an element in religious belief or religious conduct ... each person chooses the content of his own religion.<sup>37</sup>

In *Scientology* Mason ACJ and Brennan J held that religion comprises (1): belief in a supernatural Being, Thing or Principle; and (2): acceptance of canons of conduct in order to give effect to that belief.<sup>38</sup> Their Honours held that beliefs are not religious merely because believers call them religious.<sup>39</sup>

Wilson and Deane JJ nominated five non-exhaustive but ‘more important’ indicia of religion, with the absence of one not necessarily conclusive.<sup>40</sup> These were (1) belief in the supernatural; (2) ideas relating to man’s nature, place in the universe, and relation to the supernatural; (3) ideas accepted as requiring or encouraging observance of codes of conduct or involvement in practices having supernatural significance; (4) adherents form an identifiable group or groups; and (5) adherents see the collection of ideas and/or practices as a religion.<sup>41</sup>

In this thesis a belief, concept or phenomenon is religious if it satisfies either of the above definitions. The definition of religion is not of critical importance to the thesis, as the beliefs of most or all ‘religious’ groups in Australia are obviously religious.

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<sup>34</sup>(1943) 67 CLR 116.

<sup>35</sup>(1983) 154 CLR 120.

<sup>36</sup>*Jehovah’s Witnesses* at 124.

<sup>37</sup>*Id*; see also McTiernan J at 156 and Williams J at 160-161.

<sup>38</sup>At 136.

<sup>39</sup>*Ibid* 132.

<sup>40</sup>*Ibid* 174.

<sup>41</sup>*Ibid* 175; see also Murphy J at 151.

**‘Religious remedies for depression’** refers in the thesis to the remedies identified in the definition of pastoral counselling for depression in section 4.4.

**‘Sects’** and **‘cults’** are not precisely distinguished from each other or from churches, as the boundaries between them are unclear, and legal inquiry should focus on the behaviour of religious groups or individuals, not classification:

The task ultimately for the courts should be to inquire not into whether a group is to be classified as a ‘cult’ or a ‘sect’ but to assess what impact its characteristics had in the particular circumstances of the case upon a particular member.<sup>42</sup>

The term **‘serious depression’** is used in a small number of places in the thesis. It is intended to correspond to depression in the sense of major depressive disorder or bipolar disorder. It is used only to reflect the fact that some clergy may not be aware of these diagnostic categories and might instead perceive a client to have ‘serious depression’.

**‘Spiritual’** will be taken as synonymous with ‘religious’ for the purposes of the thesis.

**‘The main treatments for depression’** means in the thesis anti-depressant medication or cognitive behavioural therapy in the case of major depressive disorder, and other pharmacological treatments in the case of bipolar disorder. More detail concerning these treatments is contained in chapter three.

**‘The postulated duty of care’** means the duty of care to which reference is made in the first aim of the thesis.

**‘Unnecessarily prolonged depression’** means in the thesis ongoing depression experienced by a client of the same or greater severity as that experienced when pastoral counselling for depression was initially provided, which could have been avoided or substantially reduced had reasonable care been exercised.

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<sup>42</sup>Freckelton, I. ‘Cults, Calamities and Psychological Consequences’ (1998) 5 *Psychiatry, Psychology and the Law* 1, 5.

## Chapter 1

### INTRODUCTION

#### 1.1 Rationale

The issue of whether clergy owe a duty of care when providing counselling for depression arose in the landmark Californian case of *Nally v Grace Community Church of the Valley*<sup>1</sup> ('Nally').

On 1 April 1979, 24 year old Kenneth Mark Nally ('Nally'), who had received pastoral counselling for depression from four clergy, committed suicide by shooting himself in the head. Nally's parents ('the plaintiffs') alleged the clergy had owed their son a duty of care and sued those clergy and their church in negligence.<sup>2</sup>

When the case reached the Californian Supreme Court, Kaufman J held that a duty of care had existed. His Honour's judgment stated in part:

Several of the counselors testified that they considered themselves fully competent to treat a whole range of mental illnesses, including depression ... This asserted capacity to handle severe psychological disorders was also reflected in a Church publication entitled "Guide for Biblical Counselors" ("Guide"). Pastor Thomson was the author of the Guide which ... was required reading in Thomson's class on biblical counseling. According to Pastor Thomson ... "every emotional problem" was within the competence of the pastoral counselor ... Among the symptoms or disorders the Guide listed as falling within the pastoral counselor's domain were "drug abuse, alcoholism, phobias, mania, nervous breakdown, manic-depressive [disorder] and schizophrenia." Nally was well aware of defendants' self-proclaimed proficiency at treating severe depression and suicidal symptoms. Nally was a student in Pastor Thomson's course on biblical counseling and sought out formal or informal pastoral counseling from defendants during each of his several suicidal crises ...<sup>3</sup>

Kaufman J was in the minority on the duty of care issue, along with Broussard J, who concurred with him. Their Honours nonetheless rejected the claim because they found there had been no breach of duty.<sup>4</sup>

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<sup>1</sup>204 Cal. Rptr.303 (Cal. App. 2 Dist. 1984) (Californian Court of Appeal); 240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987) (Californian Court of Appeal); 253 Cal. Rptr 97 (Cal. 1988) (Californian Supreme Court); certiorari denied 490 US 1007 (1989) (US Supreme Court).

<sup>2</sup>*Nally* is discussed further in chapter two.

<sup>3</sup>253 Cal. Rptr. 97 (Cal. 1988), 114-115.

<sup>4</sup>*Ibid* 119.

Kaufman and Broussard JJs' conclusion that a duty of care was owed accorded with that which had been reached by a two-one majority of the Californian Court of Appeal,<sup>5</sup> an intermediate appellate court.

By way of contrast, the five-member majority of the Californian Supreme Court concluded no duty of care was owed, placing considerable emphasis on the 'pastoral' nature of the counselling, which it did not explicitly define:

Defendant Church had no professional or clinical counseling ministry, and its pastoral counseling was essentially religious in nature. Such counseling was often received through instruction, study, prayer and guidance ... According to the trial testimony of defendant Senior Pastor MacArthur, "Grace Community Church does not have a professional or clinical counseling ministry. We don't run a counseling centre as such. We aren't paid for that, and we don't solicit that. We just respond as pastors, so what we do is on a spiritual level, and a biblical level, or a prayer level ...". In essence, the defendants held themselves out as *pastoral* counselors - not as professional, medical or psychiatric counselors.<sup>6</sup> (emphasis in original)

Kaufman J strongly criticised the majority for overlooking the facts of the case:

While the majority faithfully chronicles the tragic sequence of events which led to Nally's suicide, it quite inexplicably overlooks the substantial evidence adduced by plaintiffs relating to the nature and extent of the pastoral counseling offered by defendants ... such selective citation of the record undoubtedly colors one's overall assessment of the case, and to that extent is objectionable ... How the majority could omit from its opinion [the] extensive evidence of defendants' "holding out" [themselves as competent to treat depression] is quite beyond my understanding.<sup>7</sup>

The main rationale for the thesis is its argument that should a similar case arise in Australia, the approach to be taken in deciding whether clergy who provide pastoral counselling for depression owe a duty of care ought not be along the lines of that taken by the majority of the Californian Court in *Nally*, and should involve more than classification of the counselling as pastoral.<sup>8</sup>

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<sup>5</sup>See further section 2.3.

<sup>6</sup>253 Cal. Rptr 97 per Lucas CJ at 100; Mosk, Panelli, Arguelles and Eagleson JJ concurring (Cal. 1988).

<sup>7</sup>*Ibid* 114-115.

<sup>8</sup>Australian courts may be aided by non-Australian judgments if there is no binding or sufficiently persuasive Australian authority: see *Church of the New Faith v Commissioner of Payroll Tax (Vic)* (1983) 154 CLR 120 per Mason ACJ & Brennan J at 131.

Such a case could arise. There are around 12,500 clergy in Australia,<sup>9</sup> and it is possible that some of these provide counselling for depression to some extent.<sup>10</sup>

Further rationale for the thesis is provided by the facts that counselling is not regulated by statute in Australia and very little has been said in Anglo-Australian law about the obligations of clergy who provide counselling.<sup>11</sup>

There is no mention of ‘clergy’, ‘churches’, ‘ministers of religion’ or ‘religious advisers’ in the indexes of various well known Anglo-Australian text and case books on tort.<sup>12</sup>

The English text, *Jackson and Powell on Professional Negligence* briefly refers to religious advisers, but only in the context of relationships presumed to yield undue influence.<sup>13</sup>

Even in the United States, (‘US’) consideration of the issue has been limited. Weitz noted in *Clergy Malpractice in America: Nally v Grace Community Church of the Valley*:

Because the theory of clergy malpractice was so novel and remains somewhat of a mystery today, there was very little in the way of specific secondary literature to rely on in writing this book.<sup>14</sup>

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<sup>9</sup>Rice, M. ‘Differences in cut of the cloth’ *Sydney Morning Herald* 4 June 2002: 9.

<sup>10</sup>This can probably be inferred from the handbooks of relevant educational institutions. For example the *Catholic Institute of Sydney Handbook 2002* refers to a Master of Arts (Pastoral Care and Counselling) and ‘pastoral counselling’ courses which address matters including depression and suicide - *Catholic Institute of Sydney Handbook 2002* at 45, 72, 74. Similarly see the *Australian College of Theology Undergraduate Manual 2002* at 233-234. The Australian College of Theology is an examining body offering degrees and diplomas through about 20 institutions around Australia.

<sup>11</sup>For example a well-known Australian book devotes only one sentence to such issues, stating that ‘a duty would be owed to individuals who come for counselling at least so far as the relationship of counsellor and client is concerned, (even if no fee or charge is made)’ - Fisher, S. & MacFarlane, P. 1996 *Churches, Clergy and The Law*, Federation Press, Sydney, 169.

<sup>12</sup>Eg. Fleming, J.G. 1998 *The Law of Torts* 9th edn LBC Information Services Sydney; Trindade, F. & Cane, P. 1999 *The Law of Tort in Australia* 3rd edn Oxford University Press Melbourne; Swanton, J., McDonald, B., Anderson, R. & Yeo, S. 2002 *Cases on Torts* 3rd edn The Federation Press Sydney; Hodge, W., Atkin, B., McLay, G. & Pardy, B. 1997 *Torts in New Zealand Cases and Materials* 2nd edn Oxford University Press Auckland; Linden, A.M. 1997 *Canadian Tort Law* 6th edn Butterworths Toronto; Todd, S. (general editor) 1997 *The Law of Torts in New Zealand* Brooker’s Legal Information Wellington; Walton, His Honour Judge, Cooper, R., Wood, S.E. 2001 *Charlesworth & Percy* on Negligence Sweet & Maxwell London.

<sup>13</sup>Powell, J.L., Stewart, R. (general eds) 2002, 5th edn Sweet & Maxwell London, 77.

<sup>14</sup>Weitz, 218.

## 1.2 Aims

The thesis may be broadly viewed as considering the manner in which a case resembling *Nally* might be decided if one were to arise in New South Wales.

Consideration is given to whether the client might have a cause of action in negligence against a cleric from whom pastoral counselling for depression was received, whether or not an express representation of competence to treat depression was made. Against this background, the aims of the thesis are:

First, to identify an approach for determining whether clergy who provide pastoral counselling for depression to individuals in New South Wales owe a duty of care.<sup>15</sup>

Second, to argue that the pastoral nature of the counselling is not conclusive of whether a duty of care exists.

Third, to argue that where a duty of care arises, the degree of care will in some cases include a requirement to refer the client to a general medical practitioner or mental health professional ('the duty to refer').

Fourth, to identify, to the limited and approximate extent to which it is possible in the absence of a concrete fact situation, the degree of care required for pastoral counselling for depression by clergy. Members of the Court have cautioned against attempts to precisely specify the degree of care required of a class of defendants in the abstract, in advance of particular cases.<sup>16</sup>

Fifth, to argue that breach of the duty to refer is capable of being the cause of a suicide attempt on the part of a client, and thus of damage resulting from the attempt.

The thesis is primarily concerned with the potential liability of clergy, not churches. A client bringing a claim against a cleric may also make a claim against the cleric's church. In this context, a secondary aim of the thesis is to identify the law and main issues that would be relevant if such a claim were made.

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<sup>15</sup>In relation to harm other than pure mental harm. Mental harm consequent upon other personal injury is dealt with in section 17.10. Comprehensive consideration of a duty of care for pure mental harm is beyond the scope of the thesis. Some discussion of the issue is included in Appendix A.

<sup>16</sup>See the introduction to chapter fifteen.

### 1.3 Methodology

Chapter two outlines the facts, procedural history and the judgments of the Californian Supreme Court in *Nally*. The case is of background illustrative relevance.

*Nally* is also, to a degree, the template for the aims of the thesis. The plaintiffs alleged that the duty of care said by them to be owed included a requirement to have referred *Nally* to a mental health professional, that breach of this requirement had occurred, and had caused *Nally*'s suicide.<sup>17</sup>

Consideration of the duty to refer is therefore relevant. The duty to refer is also important in its own right. It is the most significant requirement, though not the only one, which it might be both reasonable and worthwhile to impose on clergy who provide pastoral counselling for depression.<sup>18</sup>

It is appropriate to focus, in relation to causation, on whether breach of the duty to refer may be the cause of a suicide attempt by a client. The issue is raised by *Nally*, and a client may 'do what depressed persons are apt to do, namely, to attempt suicide'.<sup>19</sup> For each person who dies from suicide in Australia there are another thirty to forty people who attempt suicide.<sup>20</sup>

Further, serious physical injury from a suicide attempt is arguably the most significant form of damage, apart from death, which could occur from breach of the duty to refer or from any want of reasonable care regarding pastoral counselling for depression. Other forms of damage may also result from a suicide attempt.

Chapter three defines 'depression'<sup>21</sup> and lists its main treatments. It is useful to concentrate on depression as there is a 'high incidence' of depression in Australia.<sup>22</sup>

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<sup>17</sup>See further chapter two.

<sup>18</sup>See further chapters fourteen and fifteen.

<sup>19</sup>*NSW Insurance Ministerial Corporation v Myers* (1995) 21 *Motor Vehicle Reports* 295 per Mahoney J at 296.

<sup>20</sup>Nirui, M., Chenoweth, L. 'The Response of Healthcare Services to People at Risk of Suicide: A Qualitative Study' (1999) 33 *Australian and New Zealand Journal of Psychiatry* 361, 362.

<sup>21</sup>Depression is defined herein according to the diagnostic categories used by the American Psychiatric Association's 2000 Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision, American Psychiatric Association, Washington DC.

<sup>22</sup>Parker, G. 2002 *Dealing with Depression: A Commonsense Guide to Mood Disorders* Allen & Unwin, Sydney, 1.

Chapter four develops a definition of ‘pastoral counselling for depression’, having regard to descriptions of counselling within the counselling fields. The purpose of doing so is to identify the communication investigated by the thesis, to which the law of negligence will be applied.

The definitions of ‘counselling’ and ‘pastoral counselling’ are matters on which there is limited consensus. It is for the thesis to make a choice regarding terms used, as opposed to adopting definitions used by any particular source.

‘Pastoral counselling for depression’ is limited by definition herein to certain communication occurring within a session or sessions scheduled for the primary purpose of solving the problem of the client’s depression. The communication in *Nally* included ‘regularly scheduled counseling “sessions”’:

[F]ormal counseling was offered ... with regularly scheduled counseling “sessions” ... indeed, the Church employed a secretary whose responsibilities included the making and scheduling of such counseling appointments ... Rea [one of the defendant clergy] testified that he had formal counseling sessions with Nally during the first four months of 1978.<sup>23</sup>

The overall relationship between the defendant clergy and Nally also included ‘ad hoc’ or ‘informal’ sessions: ‘much of the counseling ... was apparently of an ad hoc ... nature ... Rea had many informal sessions [with Nally]’.<sup>24</sup>

‘Informal pastoral counselling for depression’ is also defined in chapter four. Pastoral counselling for depression and informal pastoral counselling for depression are two different situations. Pastoral counselling for depression is more likely to attract a duty of care,<sup>25</sup> and is therefore the focus of the thesis.

While it has been possible to include some discussion of whether informal pastoral counselling for depression may attract a duty of care in Appendix B, consideration of this issue in its entirety is beyond the scope of the thesis. The question of a duty of care where the overall relationship between a cleric and a client consists of both scheduled and informal counselling is addressed in Appendix B.

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<sup>23</sup>253 Cal. Rptr. 97 (Cal. 1988) at 114-115.

<sup>24</sup>*Id.*

<sup>25</sup>See generally chapters six to twelve, chapter sixteen, and particularly Appendix B.

The 'pastoral' nature of pastoral counselling for depression is described by reference to a number of indicia. These include that the counselling is provided by a cleric who is a 'non-professional counsellor',<sup>26</sup> that the counselling is wholly or primarily based on religion, and is provided free of charge.

The definition of 'pastoral counselling for depression' delineates the communication to be investigated by the thesis and is therefore of assistance. Such a definition does not, however, indicate why clergy who provide such counselling should or should not owe a duty of care.

Chapter five deals with preliminary legal matters. The purpose of the *CLA* is discussed, along with principles governing its interpretation. The *CLA* does not provide a general indication of the circumstances in which a duty of care will arise. The common law continues to apply. The provisions governing whether a public authority owes a duty of care<sup>27</sup> are not relevant to clergy or churches.

Thereafter it is argued that the *CLA*'s exemption from civil liability of persons involved in 'community work'<sup>28</sup> does not apply to pastoral counselling for depression, and that the protection of 'good samaritans' from civil liability for acts or omissions done or made in an emergency<sup>29</sup> is not generally applicable to pastoral counselling for depression.<sup>30</sup> The chapter also addresses a range of other preliminary matters before the thesis commences to squarely address the duty of care issue in chapter six.

Chapter six argues that whether the postulated duty of care exists should be determined through the application of general principles of the law of negligence, having regard to the circumstances of the particular case. Few principles of general application to duty of care can be found in previous cases.<sup>31</sup> Reasons for avoiding an approach based on consideration of the degree of analogy between clergy and mental health professionals are given.<sup>32</sup>

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<sup>26</sup>This term is defined in the Definitions section.

<sup>27</sup>Sections 40 - 46.

<sup>28</sup>Sections 59 - 61.

<sup>29</sup>Sections 57 - 58.

<sup>30</sup>Except where a cleric seeks to assist a suicidal person about to harm themselves, unless negligence by the cleric caused the risk of suicide - section 58(1) states that the protection given to good samaritans 'does not apply if it is the good samaritan's intentional or negligent act or omission that caused the injury or risk of injury in respect of which the good samaritan first comes to the assistance of the person'.

<sup>31</sup>*Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1 per McHugh J at 34.

<sup>32</sup>Section 7.2.

Chapter seven considers the Court's approach to duty of care for the provision of advice and information. The Court's approach is based on the judgment of Barwick CJ in *MLC v Evatt*,<sup>33</sup> in which his Honour identified the features of the relationship in which the law will import a duty of care for provision of information or advice. Questions of whether the speaker knew or should have known that the recipient of the information or advice was likely to rely on it, and whether such reliance would be reasonable are central to that approach.

Barwick CJ's judgment was not confined to advice or information provided in business or professional contexts, nor to cases involving purely economic loss. Rather it is of general relevance, applying where the advice or information is given in connection with a matter of serious consequence.

There is close analogy between provision of advice or information, and provision of a service,<sup>34</sup> such as pastoral counselling for depression. A case involving pastoral counselling for depression is therefore one in which the approach of Barwick CJ in *MLC* should arguably be applied.

Adapting Barwick CJ's approach to pastoral counselling for depression, it should be asked whether the cleric knew or whether a reasonable cleric would have known of a likelihood of the client relying on the counselling, and whether reliance by the client on the counselling would be reasonable.

Chapter eight considers those questions. The answers will depend on the circumstances. The circumstances likely to be of particular importance are discussed in chapter eight. It is demonstrated that the Court has rejected the notion that in order to be under a duty of care for the provision of information or advice a speaker must be professional in relation to the subject matter, or make a representation to be professional.

The elements of knowledge and reasonableness of reliance to which Barwick CJ referred in *MLC* were said by his Honour to be 'essential' elements.<sup>35</sup> That is not to say a duty of care will arise regarding the provision of advice or information, or the provision of a service, if those elements are present. Rather, it may suggest that such a duty of care will not generally arise unless they are.

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<sup>33</sup>(1968) 122 CLR 556.

<sup>34</sup>Eg. *Perre v Apand* (1999) 198 CLR 180 per McHugh J at 229. See further chapter seven.

<sup>35</sup>*MLC* at 570.

Previous cases are not of direct assistance in determining whether any further elements, apart from reasonable foreseeability of harm to the plaintiff from the defendant's conduct, would be needed or would suffice in combination with those elements to establish the postulated duty of care.

Chapter nine argues that the vulnerability of the plaintiff to the defendant's conduct, or which may be viewed as essentially the same thing, the creation or increase of a risk of injury to the plaintiff by the defendant, is an important element favouring the imposition of a duty of care. Its precise significance has not been comprehensively and definitively indicated by the Court.

The discussion of vulnerability continues in chapter ten. It is argued that in the context of pastoral counselling for depression, vulnerability of the plaintiff to the defendant's conduct may occur through reliance on pastoral counselling for depression by the client, if reasonable care is not exercised.

This could occur in two main ways. First, the pastoral counselling could divert or delay a client from use of the main treatments for depression, leading to 'unnecessarily prolonged depression',<sup>36</sup> thus rendering the client more vulnerable to loss or injury from the depression. Second, some forms of pastoral counselling may exacerbate depression.

Chapter eleven applies the test for reasonable foreseeability to pastoral counselling for depression. The *CLA* varies the test for reasonable foreseeability in relation to duty of care, including a separate test for reasonable foreseeability when a duty of care to take care not to cause mental harm is in question.<sup>37</sup> It is argued that a reasonable cleric could foresee the possibility of the possibility of harm to the client as a result of an act or omission when providing pastoral counselling for depression.

Chapter twelve considers the indicia by reference to which the 'pastoral' nature of pastoral counselling for depression has been described. It contends there is nothing talismanic about the pastoral nature of the counselling which would in itself protect a cleric from the possibility of being subject to a duty of care.

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<sup>36</sup>This term is defined in the Definitions section.

<sup>37</sup>Section 32.

Examination of policy is best done with an understanding of the likely degree of care,<sup>38</sup> and is therefore postponed until after discussion of degree of care in chapters thirteen to fifteen.

Chapter thirteen sets out general principles in relation to degree of care. The *CLA* imposes a new test for determining the standard of care required of professionals.<sup>39</sup> It is argued that these provisions do not apply to pastoral counselling for depression as defined herein. Chapter fourteen argues that reasonable care would generally require compliance with the duty to refer, if a duty of care arose. Chapter fifteen discusses the approximate overall degree of care that may be required.

Chapter sixteen considers whether there are any policy reasons not to impose the postulated duty of care. It is necessary to consider whether it is in the public interest that a duty of care be imposed, as ‘the public interest argument is an important factor to be weighed’.<sup>40</sup> It is also relevant to ask whether the imposition of a duty of care would ‘impose an unreasonable burden’<sup>41</sup> on a defendant. The policy matters discussed are relevant to one or both of these questions. It is argued that there is no convincing policy reason not to impose a duty of care.

Chapter seventeen addresses the question of whether a causal link could be established between breach of the duty to refer and a suicide attempt by a client. The Court’s approach to causation is based on common sense.

The *CLA* provides a basis for considering causation.<sup>42</sup> As it relates to causation, the intention of the *CLA* ‘is to guide the courts as they apply a commonsense approach’.<sup>43</sup> It is argued that an act of deliberate self-harm by the client will not in itself break the chain of causation, and breach of the duty to refer is capable of being the cause of a client’s suicide attempt, and therefore of damage resulting from the attempt.

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<sup>38</sup>See eg. *Modbury Triangle Shopping Centre Pty Ltd v Anzil* (2000) 75 ALJR 164 per Kirby J at 174.

<sup>39</sup>Sections 5O and 5P.

<sup>40</sup>*Esanda Finance Corporation Ltd v Peat Marwick Hungerfords* (1997) 188 CLR 241 per McHugh J at 282.

<sup>41</sup>*Modbury* per Kirby J at 179.

<sup>42</sup>Sections 5D and 5E.

<sup>43</sup>*Parliamentary Debates (Hansard)* Civil Liability Amendment (Personal Responsibility) Bill, Second Reading, 19 November 2002, Mr Egan, Treasurer, Minister for State Development, 6896, 6896.

Comprehensive consideration of damage which might occur in the absence of a suicide attempt, whether from breach of the duty to refer or some other breach of duty, is beyond the scope of the thesis. In particular, the issue of whether clergy owe a duty of care in relation to pure mental harm is beyond the scope of the thesis for reasons which were stated in the Preface.<sup>44</sup> The possibility of other modes of damage is noted in Appendix A.

Chapter eighteen identifies the law and main issues relevant to whether the cleric's church might also be liable to the client. In considering the potential liability of churches it would be useful to select one or two denominations and to examine their structures in detail. That would, however, almost require a thesis in itself and is therefore not possible herein.

Chapter nineteen states some general conclusions regarding the aims of the thesis. In relation to duty of care, it is submitted that whether a duty of care will arise for pastoral counselling for depression by clergy, in relation to harm other than mental harm, may appropriately be determined by reference to the following questions:

- (1) Whether the cleric knew, or a reasonable cleric would in the circumstances have known, of a likelihood of a client relying on the pastoral counselling for depression;
- (2) Whether such reliance, if it occurred, would be reasonable in the circumstances;
- (3) Whether the pastoral counselling for depression has the potential to increase the vulnerability of the client, if reasonable care is not exercised;
- (4) Whether harm to the client could be foreseen, in the circumstances, by a reasonable cleric due to an act or omission when providing pastoral counselling for depression;
- (5) Whether it would be unreasonable, having regard to the public interest, for the cleric to be subject to a duty of care, in the circumstances of the case and in other cases of like circumstances; and
- (6) Whether imposing a duty of care in the circumstances of the case and in other cases of like circumstances, would subject clergy to an unreasonable burden.

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<sup>44</sup>Preface, pages vi and vii.

An affirmative answer to each of the first four questions and a negative answer to the fifth and sixth questions in a particular case would result in a finding that a duty of care existed. A negative answer to any of the first four questions or an affirmative answer to either of the fifth and sixth questions would mean no duty of care.

## **Conclusion**

There was a division of opinion in the Supreme Court of California in *Nally*. The majority emphasised the pastoral nature of the counselling while overlooking important facts of the case. The main rationale for the thesis is its argument that should a similar case arise in Australia the approach taken should not be along those lines, and should involve more than classification of the counselling as pastoral.

The tort of negligence consists of a duty of care requiring conformity to a certain degree of care, a failure to comply with the requisite degree of care, and consequent damage.<sup>45</sup> The basic structure of the tort of negligence provides the basic structure for the thesis.

The duty of care issue is primarily dealt with in chapters six to twelve. Degree of care is addressed in chapters thirteen to fifteen. Chapter sixteen examines policy in light of the discussion of degree of care. Chapter seventeen concerns the causal link between breach of the duty to refer and damage from a suicide attempt. Chapter eighteen examines the law and main issues concerning the possible liability of churches. General conclusions are given in chapter nineteen.

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The next chapter is about *Nally*, a case which has in the US ‘served as a beacon for those seeking to protect the clergy from counseling malpractice’.<sup>46</sup>

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<sup>45</sup>See eg. Fleming, 115.

<sup>46</sup>Weitz, 138.

## Chapter 2

### *NALLY v GRACE COMMUNITY CHURCH OF THE VALLEY*

#### **Introduction**

This chapter outlines the facts, procedural history and the judgments of the Californian Supreme Court in *Nally*, and notes some background developments in the US both before and after *Nally*.

#### **2.1 The facts**

Unless otherwise stated, the facts below have been obtained from the judgments of the Californian Supreme Court.<sup>1</sup>

Grace Community Church of the Valley ('the church') employed about 50 pastoral counsellors, and had a congregation of more than 10,000. As noted in the previous chapter, formal and informal counselling was provided, and the church employed a secretary to schedule formal appointments.

The counselling was provided to non-members and members of the church. Clergy at the church taught classes and sold books on Biblical counselling. Nally received counselling from four clergy: MacArthur, Rea, Thomson and Cory ('the defendants').

The defendants lacked formal training in the management of depression. Pastor Rea had a conversation with one of the plaintiffs as follows:

Prior to the funeral Nally [Walter Nally, Nally's father] drove down to Grace Church to finalize the arrangements. In the course of conversations with Rea ... Walter Nally learned more about Rea, this former mechanic and fireman ... The obvious question to [Walter] Nally was, "Are you trained as a counselor? ... Rea seemed amused by the question and explained that he counseled straight from the Bible ...<sup>2</sup>

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<sup>1</sup> See 253 Cal. Rptr 97 (Cal. 1988) per Lucas CJ at 99-102 and per Kaufman J at 114-117.

<sup>2</sup> Weitz, 31. Weitz conducted 'personal interviews with the parties, lawyers, reporters and witnesses in the trial' - at 218.

The defendants nonetheless held themselves out as competent to treat ‘any type of emotional problem’ including severe depression and suicidal symptoms. Nally knew of these claims of competence.

Nally had attempted suicide in 1973, and the defendants knew about this.<sup>3</sup> They also knew of his ongoing depression and suicidal ideation. They took his intimations of suicide ‘seriously’, but persisted in trying to help him with Biblical counselling and advice to pray and read the Bible.<sup>4</sup>

His first contact with the defendants was in 1974. At this time he discussed his problems with Cory but there was no ‘formal’ counselling relationship, only ‘close friendship’.

Nally saw a secular psychologist in 1975. From 1974 - 1979, he was active in various programs and ministries at the church. The extent of the counselling for depression from the defendants during these activities is not apparent from the *Nally* judgments.

In January 1978 Nally established a relationship with Rea with whom he often discussed ‘problems with women’ and conflict with his family regarding his religious conversion. They met five times in early 1978. Rea testified that he had ‘many informal sessions’ with Nally before and after that time. According to Rea, Nally often appeared distraught and cried, saying he ‘couldn’t cope’.

Following the break-up with his girlfriend in December 1978 Nally became ‘increasingly despondent’. In mid-March 1979 Nally attempted suicide and was admitted for hospital for six days. Between December 1978 and March 1979 Nally was examined by a number of practitioners including a general practitioner, a physician and a psychiatrist.

In late March 1979 Nally stayed at MacArthur’s house. Nally discussed his depression and suicidal thoughts and MacArthur allegedly advised him to see a psychiatrist. On 1 April 1979, after his stay at the MacArthur residence had ended, Nally committed suicide at a friend’s apartment.

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<sup>3</sup> See Weitz, 32.

<sup>4</sup> 240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987), 220; 253 Cal. Rptr 97 (Cal. 1988), 100.

## 2.2 Procedural history

The plaintiffs filed a wrongful death action against the church and the four clergy. They alleged the defendants negligently failed to investigate Nally's suicidality and to refer him to a psychiatrist, and that the church and MacArthur were negligent in not ensuring the counsellors they hired and retained were adequately trained.<sup>5</sup>

Ericsson, one of the legal representatives for the defendants in *Nally*, later wrote:

[T]he *Nally* complaint alleged that the counselors at the church told Nally to read the Bible, pray, listen to taped sermons, and other church counselors while, on the other hand, they allegedly dissuaded and discouraged him from seeking professional psychiatric or psychological help.<sup>6</sup>

Of the *Nally* judgments, those in the Supreme Court of California encompass the issues raised by *Nally*, and are briefly outlined in the next section. It is unnecessary to discuss in detail the other *Nally* judgments.<sup>7</sup>

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<sup>5</sup> Allegations that the defendants intentionally inflicted emotional distress by exacerbating Nally's guilt, and encouraged or condoned his suicide were also made. Discussion of these issues is beyond the scope of the thesis.

<sup>6</sup> Ericsson, S. 'Clergyman Malpractice: Ramifications of a New Theory' 16 *Valparaiso University Law Review* 163 (1981), 172.

<sup>7</sup> At first instance *Nally* was heard in the Superior Court, Los Angeles County in 1981. Murphy J granted summary judgment for the defendants on the basis that the evidence did not disclose a triable issue of fact. (Comments made by Murphy J in granting summary judgment were extracted by the Californian Court of Appeal in its review of Murphy J's decision, (which is noted in the next paragraph of this footnote) - see 204 Cal. Rptr. 303, 311-312 (Cal. App. 2 Dist. 1984). His Honour's comments were to the effect that 'while clergy are 'not above the law', he saw no triable issue of fact.)

The plaintiffs appealed to the Californian Court of Appeal, which reversed the summary judgment. However the two majority judges did not need to consider the duty issue because of their approach taken on another issue irrelevant to the thesis - see 204 Cal. Rptr. 303 per Dalsimer AJ at 309, Gutierrez J concurring at 309 (Cal. App. 2 Dist. 1984).

Following the Court of Appeal's decision, the defendants petitioned the Californian Supreme Court for review. The Californian Supreme Court denied review and sent the matter back to the trial court. A new trial judge heard the case, as Murphy J disqualified himself because his disagreement with the Court of Appeal's decision was so strong that he did not think he could properly sit as judge - see Weitz, 98.

The plaintiffs' case took almost four weeks - see Weitz, 131. At the conclusion of the plaintiff's case Kalin J dismissed the case on the defendants' motion. The case therefore never reached the jury. Kalin J held that the defendants had owed no duty to Nally, mainly on the basis that concepts of religious freedom and separation of church and state in the First Amendment of the US Constitution precluded imposition of duty. Kalin J also rejected the plaintiffs' allegation of intentional infliction of emotional distress. The judgment of Kalin J is reported at 5 *Religious Freedom Reporter* 91 (May 1985).

The plaintiffs again appealed to the Californian Court of Appeal. The two majority judges held that established Californian tort law imposed a duty of care on counsellors of suicidal individuals, regardless of whether the counselling was religious, notwithstanding the First Amendment - see 240 Cal. Rptr 215 per Johnson AJ at 219 & 232, Thompson APJ concurring at 243 (Cal. App. 2 Dist. 1987). The degree of care required was to refer suicidal individuals to appropriate medical personnel - *ibid*. The two majority judges sent the case back to the trial court for further proceedings consistent with their opinion.

However the defendants appealed that decision to the Californian Supreme Court, the five-member majority of which held that the defendants had owed no duty (and also rejected the allegation of intentional infliction of emotional distress) - see 253 Cal. Rptr 97 (Cal. 1988). The plaintiffs then appealed to the US Supreme Court, which, as noted in this section, declined to review the decision of the Californian Supreme Court.

### 2.3 Judgments of the Californian Supreme Court

A majority of the Californian Supreme Court held that the defendants had not owed Nally a duty of care.<sup>8</sup> They focussed on the facts that the counselling was ‘essentially religious’ in nature,<sup>9</sup> that the church did not provide ‘professional’ or ‘clinical’ counselling,<sup>10</sup> and that no charge was made for the counselling.<sup>11</sup>

The majority appeared to ignore some of the important facts of the case, including the defendants’ express representations of competence to treat depression, and Nally’s reliance on these representations:

Defendants here patently held themselves out as competent to counsel the mentally ill, and Nally responded to these inducements, placing his psychological and ultimately his physical well-being in the defendants’ care.<sup>12</sup>

The majority cited a range of public interest considerations which in their view told against imposition of a duty of care on the defendants.

These included the notions that imposing a duty of care could have a ‘deleterious effect on counselling in general’ by discouraging ‘teen hotlines’ and ‘band aid counseling’; that those ‘most in need of help’ might be deterred from ‘seeking treatment out of fear that their private disclosures could subject them to involuntary commitment to psychiatric facilities’; that ‘the Legislature has exempted clergy from licensing requirements’ applicable to other counsellors; that voluntary assistance efforts should not be discouraged; and that complex policy decisions would be involved.<sup>13</sup>

These considerations and other policy implications of imposing a duty of care on clergy for pastoral counselling for depression are discussed elsewhere in the thesis in an Australian context.<sup>14</sup>

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<sup>8</sup>253 Cal. Rptr 97 (Cal. 1988) per Lucas CJ at 110, Mosk, Panelli, Arguelles and Eagleson JJ concurring at 113.

<sup>9</sup>*Ibid* 100.

<sup>10</sup>*Id.*

<sup>11</sup>*Ibid* 109.

<sup>12</sup>*Ibid* 118.

<sup>13</sup>*Ibid* 109-110.

<sup>14</sup>See particularly section 5.5 and chapter sixteen.

In holding that the defendants had owed Nally a duty of care, Kaufman J considered the amount of counselling the defendants provided to Nally, and that the defendants had made representations of competence to treat depression.<sup>15</sup>

Kaufman J rejected the policy considerations cited by the majority, and found the evidence more than sufficed to impose a duty to advise suicidal individuals to seek competent medical care.<sup>16</sup>

On appeal by the plaintiffs, the US Supreme Court declined to review the Californian Supreme Court's decision, but gave no reasons.<sup>17</sup>

## 2.4 Historical background

*Nally* generated substantial attention in US media,<sup>18</sup> religion journals<sup>19</sup> and legal journals.<sup>20</sup> However massive opposition to the possibility of liability of clergy for

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<sup>15</sup> 253 Cal. Rptr 97 (Cal. 1988), 114-116.

<sup>16</sup> *Ibid* 117-119.

<sup>17</sup> The US Supreme Court merely stated 'Petition for writ of certiorari to the Supreme Court of California April 3 1989 denied' - 490 US 1007 (1989). (No reasons were given for the denial of certiorari in several other cases at 490 US 1007 (1989)). Weitz states, at 198, that certiorari was denied because no federal constitutional issues were involved. While the majority of the Californian Supreme Court referred to First Amendment issues, it refrained from deciding the case on that basis. Weitz suggests (at 196) that this was a deliberate strategy to avoid the possibility of review by the US Supreme Court. As to the First Amendment and section 116 of the Australian constitution, see section 5.5.

<sup>18</sup> See Barker, E. 'Clergy Negligence: Are Juries Ready to Sit in Judgment?' 22 *Trial* 56, 59 (July 1986).

<sup>19</sup> Eg. Augspurger R.E. 'Legal Concerns of the Pastoral Counselor' (1980) 29 *Pastoral Psychology* 109; Bernstein B.E. 'A Potential Peril of Pastoral Care: Malpractice' (1980) 19 *Journal of Religion and Health* 48; Chappelle, W. 'A Series of Progressive Legal and Ethical Decision Making Steps for Using Christian Spiritual Intervention in Psychotherapy' (2000) 28 *Journal of Psychology and Theology* 43; Denham, T.E. & M.L. 'Avoiding Malpractice Suits in Pastoral Counseling' (1986) 35 *Pastoral Psychology* 83; Dickson C. & Bloss, J.L. 'A Minister and a Lawyer Look At: Clergy Malpractice' *Church Management - The Clergy Journal* 8 (July 1989); Marty, M.E. 'Ministerial Malpractice' 96 *Christian Century* 511 (1979); Maust, J. 'Clergy, Malpractice Insurance: First Sign of Substance for a Profitable Myth', *Christianity Today* 44 (May 23, 1980).

<sup>20</sup> For example, Anders, M. 'Religious Counseling - parents allowed to pursue suit against church and clergy for son's suicide - *Nally v Grace Community Church*' *Arizona State Law Journal* 213 [1985]; Anthony M.A. 'Through the Narrow Door: An Examination of Possible Criteria for a Clergy Malpractice Action' 15 *University of Dayton Law Review* 493 (1990); Barker, E. & Wilkinson, A.P. 'Clergy Malpractice: Cloaked by the Cloth?' 26 *Trial* 36 (May 1990); Bartel M.R. 'Clergy Malpractice After *Nally*: Touch Not My Anointed, and to My Prophets Do No Harm' 35 *Villanova Law Review* 535 (1990); Breecher, M. 'Ministerial Malpractice', *Liberty* 15 (March/April 1980); Burek L.M. 'Clergy Malpractice: Making Clergy Accountable To a Lower Power' 14 *Pepperdine Law Review* 137 (1986); Burton, M.A. '*Nally v Grace Community Church*: Is There a Future For Clergy Malpractice Claims?' 37 *Santa Clara Law Review* 467 (1997); Chase, J. 'Clergy Malpractice: The Cause of Action That Never Was' 18 *North Carolina Central Law Journal* 163 (1989); Cupp, R.L. 'Religious Torts: Applying the Consent Doctrine as Definitional Balancing' 19 *University of California Davis Law Review* 949 (1986); Esbeck, C.H. 'Tort Claims Against Churches and Ecclesiastical Officers: The First Amendment Considerations' 89 *West Virginia Law Review* 1 (1986); Fiorillo M.J. 'Clergy Malpractice: Should Pennsylvania Recognize a Cause of Action for Improper Counseling by a Clergyman?' 92 *Dickinson Law Review* 223 (1987); Girdner, B. 'Did Pastors Spur Suicide?' *The National Law Journal* 6 (May 13, 1985); Girdner, B. 'To Err is Human' *California Law* 21 (Aug 1985); Graziano, S.G. 'Clergy Malpractice' 12 *Whittier Law Review* 349 (1991); Hanson, R.K. 'Clergy Malpractice: Suing Ministers, Pastors and Priests for Ungodly Counseling' 39 *Drake Law Review* 597 (1989-90); Hudson, T.L. 'Seeing In a Mirror Dimly? Clergy Malpractice as a Cause of Action: *Nally v Grace Community Church*' 15 *Capital University Law Review* 349 (1986); Klee, K.A. 'Clergy Malpractice: Bad News For the Good Samaritan or a Blessing In Disguise?' 17 *Toledo Law Rev.* 209 (1985); Lehman, J.K. 'Clergy Malpractice: A Constitutional Approach' 41 *South Carolina Law Review* 459 (1990); McMenamin, R.W. 'Clergy Malpractice' *Case and Comment* 3 (Sept-Oct 1985); Postel, C.J. 'Clergy Malpractice: An Emerging Field of Law' 21 *Trial*

counselling was mobilised in the US during the 1980s.<sup>21</sup>

Ericsson, defendants' counsel in *Nally*, claims that he 'derailed efforts to pass a "Clergy Malpractice Law" in California' in 1986.<sup>22</sup> One commentator noted:

The protest by clergy, church officials and related organisations against allowing clergy malpractice claims has been overwhelming.<sup>23</sup>

Intellectual and moral confusion has abounded in the US on the subject. This is not surprising in a country in which religiously motivated child abuse and neglect has been protected by law in many states.<sup>24</sup>

For example, a majority of the Ohio Supreme Court actually held that because, among other reasons, the Ohio legislature had abolished actions based on alienation of affections, clergy could not be sued for seducing spouses while providing marital counselling.<sup>25</sup> It was left to a dissenting judge to state the obvious:

This case does not resemble your garden variety seduction scenario. The wife did not get involved with the milkman, the mailman or the guy next door. Here, the couple's minister, under a guise of offering pastoral counselling services, abused the trust placed in him. This trust was the *raison d'être* of the relationship. It also distinguishes this case from those which the legislature intended to abolish when it did away with amatory actions. This distinction also applies to *Strock*'s claim of misrepresentation - this was not your average lover's ruse.<sup>26</sup>

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91 (Dec. 1985); Rouse K.B. 'Clergy Malpractice Claims: A New Problem for Religious Organisations' 16 *Northern Kentucky Law Review* 383 (1988); Taylor, M. '*Nally v Grace Community Church*: the Future of Clergy Malpractice Under Content Based Analysis' 3 *Utah Law Review* 661 (1990); ; Troyer, R.C. 'Protecting the Flock from the Shepherd: A Duty of Care and Licensing Requirement for Clergy Counselors' 30 *Boston College Law Review* 1179 (1989).

<sup>21</sup> See eg. New York Times '1,500 Religious Groups Helping to Fight Clergy Malpractice' *The New York Times* 26 April 1988: B7.

<sup>22</sup> [www.advocatesinternational.org/ericssoncv.htm](http://www.advocatesinternational.org/ericssoncv.htm).

<sup>23</sup> Taylor, T. 'Clergy Malpractice: Avoiding Earthly Judgment' 5 *Brigham Young University Journal of Public Law* 119 (1990), 136.

<sup>24</sup> See Dwyer, J. 'Parents' Religion and Childrens' Welfare: Debunking the Doctrine of Parents' Rights' 82 *California Law Review* 1371 (1994).

<sup>25</sup> *Strock v Pressnell* 75 ALR 4th 729 per Wright J at 738 - 743 (1988); Moyer CJ, Locher, Holmes, & Brown JJ concurring.

<sup>26</sup> *Ibid* per Sweeney J at 748.

*Nally* concluded in 1989, yet twelve years later Russon ACJ of the Utah Supreme Court could make the almost accurate claim that courts in the US have ‘uniformly rejected claims for clergy malpractice under the First Amendment.’<sup>27</sup>

Two exceptions are the Californian Court of Appeal in *Nally*,<sup>28</sup> and the Washington Supreme Court in *Lund v Caple* which did not rule out liability of clergy for counselling.<sup>29</sup>

US insurance companies began offering malpractice insurance to clergy in 1979.<sup>30</sup> It has been asserted that ‘clergy malpractice’ was an invention of the US insurance industry to generate business.<sup>31</sup> It appears that *Nally* was the second reported case involving the liability of clergy for the *content* of counselling.<sup>32</sup>

A case bearing slight resemblance to *Nally* is *White v Blackburn*, where the Utah Court of Appeal declined to impose a duty on a bishop to further inquire into family problems alleged by a 17 year old, and then if beyond his expertise, refer the minor to others more qualified.<sup>33</sup>

It seems the minor sought help only to locate an older brother, and the bishop did not undertake to do more than pay for an airline ticket for him for that purpose. The case was brought by his mother, who objected to the bishop’s failure to properly establish that she consented to the trip.<sup>34</sup>

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<sup>27</sup> *Franco et al v The Church of Jesus Christ of Latter-day Saints et al* 21 P.3d 198, 204 (Utah 2001). The First Amendment of the US Constitution states: ‘Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof, or abridging the freedom of speech ...’. The irrelevance of freedom of religion and speech, and notions of separation of church and state to the existence and scope of the duty of Australian clerical counsellors is explained in section 5.10.

<sup>28</sup> See section 2.2.

<sup>29</sup> 675 P2d 226 per Brachtenbach CJ at 229 (Wash. 1984). *Lund* involved sexual misconduct by a cleric with a counselling client.

<sup>30</sup> Funston, C. ‘Made Out of Whole Cloth? A Constitutional Analysis of the Clergy Malpractice Concept’ 19 *California Western Law Review* 507, 508 (1983).

<sup>31</sup> Ericsson, 164.

<sup>32</sup> In *Carrieri v Bush* 62 Wn.2d 536 (1966) the defendant cleric counselled the plaintiff’s wife and was sued for causing, through advice given, dissension between husband and wife. According to the American Association of Trial Lawyers and The Christian Legal Society in Washington *Nally* was the first case ‘of its kind’ - see Cummings, J. ‘Suit Against Clergy in a Suicide Case is Reinstated’ *The New York Times*, 20 September 1987: 26. *Nally* was not the first case against religious groups in a psychological treatment context - see for example *Previn v Tenacre* 70 F2d 389 (1933) involving treatment of the plaintiff for ‘depressive melancholia’ by Christian Scientists, however the issue was not counselling negligence but rather alleged fraud and unlawful physical restraint.

<sup>33</sup> 787 P2d 1315, per Garff J at 1319, Davidson & Bullock JJ concurring (Utah App. 1990).

<sup>34</sup> *Ibid* per Garff J at 1316. See also *Wollersheim v Church of Scientology* 260 Cal. Rptr 331 (Cal. App. 2 Dist. 1989): negligent infliction of emotional injury from psychological practices was alleged in this case, however the issue received scant consideration.

Weitz reported in 2001 that Grace Community Church continued to counsel people in accordance with religious belief:

[I]n the immediate aftermath [of the case] both MacArthur and Ericsson stated the church would continue to counsel as it always had ... Grace Church continues to counsel people in accordance with the biblical beliefs that it embraces ...<sup>35</sup>

## Conclusion

*Nally* was clearly a landmark case which is of considerable background and illustrative relevance to the thesis. It did not involve a typical pastoral counselling situation but rather the application of religious ideas to the serious temporal problem of depression.

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‘Many different methods have been employed in the literature to classify cases of “depression”.’<sup>36</sup> In the next chapter ‘depression’ is defined for the purposes of the thesis.

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The plaintiff was awarded damages for *intentional* emotional injury. The case was concluded in 2002 when the defendant paid the damages plus interest - Reuters ‘Former Scientologist finally collects \$16m’ *Sydney Morning Herald* 13 May 2002: 9.

<sup>35</sup>Weitz, 207.

<sup>36</sup>*National Health and Medical Research Council 1997 Clinical Practice Guidelines for depression in young people*, Australian Government Publishing Service, Canberra, 8.

## Chapter 3

### DEPRESSION AND ITS TREATMENTS

#### Introduction

The thesis does not argue that clergy owe a duty of care regarding persons with minor unhappiness or depression, even where symptoms are not merely transitory. Rather, depression is defined as ‘major depressive disorder’ and ‘bipolar disorder’.<sup>1</sup>

The thesis only examines situations where clergy provide pastoral counselling for depression perceiving the client to be depressed in the above sense, or, if unaware of those diagnostic categories, perceiving the client to be seriously depressed.<sup>2</sup>

Cases where clergy do not perceive the client to be depressed in the above sense are beyond the scope of the thesis. This is because it is unreasonable to expect clergy to diagnose depression,<sup>3</sup> and in reality clergy would be most unlikely to face litigation regarding ‘minor’ depression, let alone successful litigation. Should clergy wrongly conclude that a client is depressed, they could not be held liable for inadequate counselling for the non-existent ‘depression’.

There is not, in general, a need to distinguish between major depressive disorder and bipolar disorder for the purposes of the thesis as both are serious conditions and most people with bipolar disorder also experience major depressive episodes.<sup>4</sup>

They two conditions may require different management.<sup>5</sup> That is further reason to consider whether clergy who provide pastoral counselling for depression owe a duty of care which includes referral of the client to a general practitioner or mental health professional, as such referral may lead to diagnosis, rather than a matter which creates a general need to treat bipolar and non-bipolar depression differently within the thesis.

Reference is made in the thesis to the *National Health and Medical Research Council*

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<sup>1</sup> See section 3.2.

<sup>2</sup> See the definition of ‘pastoral counselling for depression’ in section 4.4.

<sup>3</sup> See section 3.7.

<sup>4</sup> See section 3.4.

<sup>5</sup> See section 3.8.

*Clinical Practice Guidelines for depression in young people* ('the *NHMRC Guidelines*').<sup>6</sup> While this publication relates to 'young people', defined therein as being aged 13-20, it is appropriate to refer to it even though 'client' is defined herein as a person aged 18 or more who receives pastoral counselling for depression.<sup>7</sup> Before defining depression, the relevance of the *NHRMC Guidelines* is explained.

### **3.1 The relevance of the *NHRMC Guidelines***

Despite the focus of the *NHMRC Guidelines* on 'young people', the publication is of relevance to adults. The diagnostic criteria for adult depressive disorder are 'almost identical' to those for adolescent depressive disorder,<sup>8</sup> and 'it is now recognised that young people suffer from depressive symptoms and disorders which are similar in nature and severity to those seen in adults'.<sup>9</sup> Further, much of the evidence on which the *NHMRC Guidelines* are based was obtained from studies of treatment of adults.<sup>10</sup>

The *NHRMC Guidelines* rely on the classificatory system for depression used in the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition*, published by the American Psychiatric Association in 1994,<sup>11</sup> whereas the thesis defines depression according to the more recent *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision*.

This does not create incongruity between the *NHMRC Guidelines* and the thesis, as the diagnostic criteria for major depressive disorder have 'undergone relatively few changes since ... first formulated in the early 1970s'.<sup>12</sup>

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<sup>6</sup>The NHMRC was established by the federal government in 1936 and became a statutory body under the *NHMRC Act* 1992. Its charter includes raising the level of individual and public health in Australia.

<sup>7</sup>Guidelines for treatment of depression (apart from post-natal depression) in relation to those over 20 have not been published by the NHMRC as at 31 March 2005. There is little difficulty in applying the *NHMRC Guidelines* to treatment of those over 20 for the purposes of this thesis. Apart from differences in the availability of evidence as to the efficacy of certain pharmacological treatments in young people compared with adults, and special requirements of young people (which are made clear within the document and can be ignored for the purposes of this thesis), the *NHMRC Guidelines* do not identify any differences in the optimal management of depression in young people compared with adults in general, at 2.

<sup>8</sup>*NHMRC Guidelines*, 11.

<sup>9</sup>*Ibid* 8.

<sup>10</sup>See 'References', 159-173.

<sup>11</sup>American Psychiatric Association 1994 *Diagnostic and Statistical Manual of Mental Disorders* 4th edn, American Psychiatric Association, Washington DC.

<sup>12</sup>First, M.B., Frances, A., & Pincus, H.A. 2004 *DSM-IV-TR Guidebook: The Essential Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, American Psychiatric Publishing, Inc. Arlington, US, 186.

### 3.2 Defining depression

The definition of depression is a matter about which there is limited consensus among experts, some of whom have highlighted definitional difficulties, for example:

For 2000 years the issue of whether there is only one type of depression which varies in degree, or more than one type of depression has been argued philosophically [and] academically ...<sup>13</sup>

There is no consensus on whether depression is an array of specific disorders or a general indicator of unhappiness that varies mainly in intensity ... The very fact that [the definition of depression] still stimulates debate among experts in the field ... testifies to our failure to understand the basic nature of depression.<sup>14</sup>

[T]here are many situations in which a diagnosis seems almost pathetically inadequate to convey what we feel to be the essence of the patient's predicament ... the majority of patients do not conform to the tidy stereotyped descriptions found in textbooks.<sup>15</sup>

For the purposes of the thesis 'depression' will denote 'major depressive disorder', or 'bipolar disorder' as described by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision* ('*DSM-IV-TR*').<sup>16</sup> While major depressive disorder varies in severity,<sup>17</sup> it is by definition a serious condition, as will be seen in the next section.

The DSM-IV-TR classificatory system for depression is preferred by the thesis to the diagnostic criteria for depression stated in the World Health Organisation's *International Classification of Disease Symptom Checklist for Mental Disorders*.<sup>18</sup> The DSM classificatory system is preferred by the *NHMRC Guidelines* as seen above.

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<sup>13</sup>Parker, G. 1978 *The Bonds of Depression* Angus & Robertson Publishers Australia, 9.

<sup>14</sup>Beutler, L.E., Clarkin, J.F. & Bongar, B. 2000 *Guidelines for the Systematic Treatment of the Depressed Patient* Oxford University Press, New York, 218.

<sup>15</sup>Kendall, R.E. 1999 *The Role of Diagnosis in Psychiatry* Blackwell Scientific Publications Oxford, 2-3.

<sup>16</sup>2000 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision*, American Psychiatric Association, Washington DC.

<sup>17</sup>*American Psychiatric Association Practice Guideline for the Treatment of Patients With Major Depressive Disorder (Revision)* (2000) 157 *American Journal of Psychiatry* (Supplement), 7.

<sup>18</sup>World Health Organisation 1996 *International Classification of Disease Symptom Checklist* Hogrefe & Hugo Publishers, Seattle.

### 3.3 Major Depressive Disorder

‘The primary mood disorders are divided into the unipolar ... and the bipolar’.<sup>19</sup> The unipolar disorders include major depressive disorder, which consists of one or more major depressive episodes.<sup>20</sup> The *DSM-IV-TR* criteria for a major depressive episode are five or more of the following symptoms, present nearly every day during the same two week period, including at least one of the first two:

- (1) Depressed mood most of the day;
- (2) Markedly diminished interest or pleasure in all or almost activities most of the day;
- (3) Significant weight loss or weight gain, or decrease or increase in appetite;
- (4) Insomnia or hyposomnia;
- (5) Psychomotor agitation or retardation;<sup>21</sup>
- (6) Fatigue or loss of energy;
- (7) Feelings of worthlessness or excessive or inappropriate guilt;
- (8) Diminished ability to think or concentrate, or indecisiveness;
- (9) Recurrent thoughts of death or suicidal ideation, or a suicide attempt.<sup>22</sup>

In order to constitute a major depressive episode the symptoms must cause significant distress or impairment in social, occupational, or other important areas of functioning; not be due to drug abuse, medication, or a medical condition; and not be ‘better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, ... preoccupation with worthlessness, suicidal ideation or psychomotor retardation’.<sup>23</sup>

Medical conditions which may produce depressive symptoms include glandular fever, hepatitis, other viral conditions, endocrine disorders, metabolic abnormalities, and nervous system disorders.<sup>24</sup> The *Mental Health Act 1990* (NSW) specifies behaviour which may not be considered in itself as evidence of depression.<sup>25</sup>

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<sup>19</sup> *DSM-IV-TR Guidebook*, 198.

<sup>20</sup> *Id.*

<sup>21</sup> Psychomotor agitation is manifested by feelings of restlessness, pacing and an inability to sit still. In psychomotor retardation, the person may seem to move and think as if in slow motion, for example taking a long time to get dressed in the morning and talking more slowly - *DSM-IV-TR Guidebook*, 189.

<sup>22</sup> *Ibid* 186-187.

<sup>23</sup> *Ibid* 187.

<sup>24</sup> *NHMRC Guidelines*, 122.

<sup>25</sup> Sections 11 (1)(b) and (f) provide that persons are not mentally ill merely because they manifest particular religious belief or

### 3.4 Bipolar disorder

Bipolar disorder is a mood disorder which includes manic episodes.<sup>26</sup> ‘Most people with Bipolar Disorder also experience Major Depressive Episodes’.<sup>27</sup> In practice a person with bipolar disorder may be unlikely to attend counselling with a cleric, or any practitioner:

Because patients with manic episodes generally have tons of energy, terrible judgment and minimal insight, they often get into a great deal of trouble and are impossible to treat in an outpatient setting. Once out of the office, the patient is likely never to return.<sup>28</sup>

A manic episode consists of a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week, with at least three of the following symptoms, (or four if the mood is only irritable) have been present to a significant degree:

- (1) Inflated self-esteem or grandiosity;
- (2) Decreased need for sleep;
- (3) More talkative than usual;
- (4) Racing thoughts;
- (5) Distractibility;
- (6) Increase in goal-directed activity;
- (7) Excessive involvement in pleasurable activities with high potential for painful consequences.<sup>29</sup>

Those with bipolar disorder may also experience a ‘mixed episode’ which is characterised by rapidly alternating mood where all but the duration criteria for both a major depressive episode and a manic episode are met on an almost daily basis.<sup>30</sup>

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activity. Similarly section 11 provides that persons are not mentally ill merely because of political or philosophical belief, sexual preference or immoral, illegal or anti-social conduct. Lack of knowledge of particular religious customs, beliefs and values may cause confusion about what is disturbed behaviour, and religious peculiarities to be misinterpreted as pathological. Without entering debate about religious matters with clients, counsellors should make simple inquiries into religious experience and convictions, so as not to remain ignorant of any doctrines causing concern.

<sup>26</sup> *DSM-IV-TR Guidebook*, 206.

<sup>27</sup> *NHMRC Guidelines*, 15.

<sup>28</sup> *DSM-IV-TR Guidebook*, 192.

<sup>29</sup> *Id.*

<sup>30</sup> *NHMRC Guidelines*, 13. Similarly see *DSM-IV-TR Guidebook*, 195.

### 3.5 'Minor' depression is beyond the scope of the thesis

In ordinary conversation nearly any mood with an element of sadness or unhappiness could be termed 'depressed'. Conditions which could be described as 'minor' depression include 'depressed mood',<sup>31</sup> 'depressive syndrome'<sup>32</sup> and 'dysthymic disorder'.<sup>33</sup>

Dysthymic disorder is the most significant of these conditions. It consists of depression of 'minor' severity but present for two years or more. Parker says dysthymia is 'a diagnosis introduced into recent North American DSMs [Diagnostic and Statistical Manuals] to describe ... depression that is of 'minor' severity but present for two years or more'.<sup>34</sup> These conditions are beyond the scope of the thesis.

### 3.6 Causes of and risk factors for depression

The causes of depression may be biological, psychological or social:

Biological (for example, genetic, the effects of drugs and/or specific medical problems); psychological (for example, low self-esteem, personality style); and social (for example distressing life events, dysfunctional relationship).<sup>35</sup>

A number of risk factors for depression have been identified:

After decades of intensive research, a number of risk factors for depression have been described for Western samples: being female, experiencing negative and stressful life events, being physically ill, lacking education, having financial difficulties, not working, and lacking social support.<sup>36</sup>

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<sup>31</sup> Depressed mood 'refers to the presence of sadness, unhappiness, or blue feelings for an unspecified period of time' - *NHMRC Guidelines*, 10. Depressed mood is 'not classified as a clinical disorder' - *id.*

<sup>32</sup> Depressive syndrome is a slightly more severe phenomenon than depressed mood, consisting of such a mood plus other negative feelings such as loneliness or worthlessness - *id.*

<sup>33</sup> Dysthymic disorder consists of depressed mood for most of the day, for more days than not, for at least two years and the presence while depressed of at least two of the following: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, or feelings of hopelessness. During the two year period the person has never been without the symptoms for more than two months at a time - *DSM-IV-TR Guidebook*, 202.

<sup>34</sup> Parker, 2002, 129.

<sup>35</sup> Parker, 2002, 67.

<sup>36</sup> Tsai, J.L., Chentsova-Dutton, Y. 'Understanding Depression Across Cultures' in Gotlib, I.H. & Hamman, C.L. 2002 *Handbook of Depression* Guilford Press, New York, 467, 482.

### 3.7 Can clergy diagnose depression?

The *NHMRC Guidelines* refer to a 'semi-structured developmental screening' interview for use by general practitioners 'and other non-specialists' to facilitate the early detection of depression. This interview 'cannot be used for diagnosing depression' but 'may serve a useful role in identifying young people for whom a more comprehensive clinical interview is indicated'.<sup>37</sup>

Thus clergy could not reliably diagnose depression or distinguish it from other conditions, nor be expected to do so. This would not preclude a duty of care when providing pastoral counselling for depression - should they do so they will have concluded that the client is depressed, as discussed in the introduction to this chapter.

### 3.8 Treatments for depression

The *NHMRC Guidelines* were prepared by practitioners from psychiatry, general practice and psychology,<sup>38</sup> and 'presents the scientific or other evidence' on which its statements are based.<sup>39</sup>

According to the *NHMRC Guidelines* there are three types of treatment for major depressive disorder. These are pharmacological, psychological, and physical.<sup>40</sup>

The pharmacological treatments consist of anti-depressant medications of three different types - tricyclic antidepressants, monoamine oxidase inhibitors, and selective serotonin re-uptake inhibitors.<sup>41</sup>

It is unnecessary to discuss the differences between them. Some of them are of 'probably efficacy' and some are of 'unlikely efficacy needing further investigation'.<sup>42</sup> The *NHMRC Guidelines* mention only two psychological treatments. These are

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<sup>37</sup> *NHMRC Guidelines*, 59.

<sup>38</sup> *Ibid* 6.

<sup>39</sup> *Ibid* 3.

<sup>40</sup> *Ibid* 69.

<sup>41</sup> *Id.*

<sup>42</sup> *Ibid* 75, 79, 81.

cognitive behavioural therapy and psychoanalysis. Psychoanalysis ‘involves an exploration of automatic, unconscious solutions to conflict’.<sup>43</sup> ‘Further research is required to establish the benefits, if any, of psychoanalysis’.<sup>44</sup>

Cognitive behavioural therapy is a treatment of ‘confirmed efficacy’.<sup>45</sup> Methods commonly incorporated into cognitive behavioural therapy programs include cognitive restructuring,<sup>46</sup> relaxation training,<sup>47</sup> social skills training,<sup>48</sup> and interpersonal problem solving therapy.<sup>49</sup>

Parker says of psychological treatments for depression:

Non-physical treatments such as counselling or psychotherapy are best viewed as adjunctive ... their usefulness and importance depends to a great extent on the skills and interpersonal style of the practitioner.<sup>50</sup>

Physical treatments for depression include phototherapy, exercise, and electroconvulsive therapy.<sup>51</sup> There is limited evidence of their efficacy.<sup>52</sup>

The *American Psychiatric Association Practice Guideline for the Treatment of Patients With Major Depressive Disorder (Revision)*<sup>53</sup> (‘the *APA Guideline*’) refers to a similar list of treatments for major depressive disorder as the *NHMRC Guidelines*.<sup>54</sup>

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<sup>43</sup> *Ibid* 75.

<sup>44</sup> *Id.*

<sup>45</sup> *Ibid* 70.

<sup>46</sup> ‘[R]eplacement of unhelpful, negative thinking ... with more constructive ... thinking’ - *ibid* 71.

<sup>47</sup> ‘[I]nstruction in progressive muscle and other relaxation techniques’ - *id.*

<sup>48</sup> ‘[T]raining in skills important for successful social interactions’ - *id.*

<sup>49</sup> ‘[T]he systematic identification and resolution of relationship and life problems contributing to the depression’ - *ibid*, 74.

<sup>50</sup> Parker, 2002, 116-117.

<sup>51</sup> *NHMRC Guidelines* 78-79.

<sup>52</sup> *Ibid* 80.

<sup>53</sup> (2000) 157 *American Journal of Psychiatry* (Supplement).

<sup>54</sup> *APA Guideline*, 28-34.

The *APA Guideline* applies to ‘patients 18 years of age and older’,<sup>55</sup> and states:

Cognitive behavioural therapy [has] ... the best-documented effectiveness in the literature for the specific treatment of major depressive disorder ... although some data suggest that cognitive behavioural therapy alone may be effective for patients with ... major depressive disorder, most such patients will require medication.<sup>56</sup>

In relation to bipolar disorder, the *NHMRC Guidelines* indicates there are five treatments for bipolar disorder: lithium, carbamazepine, sodium valproate, electroconvulsive therapy and psychological therapy.<sup>57</sup>

There is ‘a paucity of literature concerning the psychological treatment of bipolar disorder’,<sup>58</sup> and it is unnecessary to discuss the physical and pharmacological treatments for bipolar disorder.

### **3.9 The value of pastoral counselling**

There is limited evidence of the efficacy of pastoral counselling for depression, and the scientific quality of studies about religion and health should not be assumed:

We have described concerns about the scientific quality of the literature on religion and health, arguing that it is severely compromised by significant methodological problems that render the evidence of a link between religion and health weak and inconclusive.<sup>59</sup>

That said, it appears that pastoral counselling for depression may benefit some people, particularly when reasonable care is exercised. A sense of meaninglessness has been implicated as a cause of depression. The *NHMRC Guidelines* make reference<sup>60</sup> to an article which states:

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<sup>55</sup> *APA Guideline*, 1.

<sup>56</sup> *Ibid* 11.

<sup>57</sup> *NHMRC Guidelines*, 81.

<sup>58</sup> *Ibid* 85.

<sup>59</sup> Sloan, R.P. & Bagiella, E. ‘The Literature on Religion and Health: Caveat Emptor’ (2004) 58 *Journal of Pastoral Care and Counseling* 271, 271.

<sup>60</sup> *NHMRC Guidelines*, 35.

I believe that behind suicide and other ... problems also lies a profound and growing failure of the culture of western industrial societies - a failure to provide a sense of meaning, belonging and purpose in our lives, and a framework of values ... that ... sustain its members through the trouble and strife of their personal lives.<sup>61</sup>

It has also been argued in the *American Journal of Psychotherapy*:

[P]roblems of meaninglessness [may] arise as one part of a broader ... syndrome, such as depression ... For example, persons who are depressed, especially those who are suicidal, will frequently describe themselves as without hope, unable to derive meaning or satisfaction from anything, and plagued by a feeling that there is “no point” to their lives ... in some of these cases (especially cases of depression) the sense of meaninglessness itself will be at the cause of the broader problem.<sup>62</sup>

Religion can provide ‘provide the basis for a sense of meaning [and] direction ... and invest potentially alienating situations with meaning’,<sup>63</sup> and thus protect against or alleviate depression.

While not specifically religious, altruistic activity may also provide meaning:

A depressed person needs to become involved in doing something for others, for in this way he breaks the vicious circle of self-centredness which is often a cause of his emotional problems.<sup>64</sup>

Pastoral counselling may be particularly useful where physical illness is also present:

Recent studies ... with hospitalized medically ill patients have ... found that religious coping behaviours (such as church attendance, prayer, reading of various religious literature, and attitudes of trust or faith in God) appear to buffet against the stresses of hospitalization and medical illness ... Both depressive symptoms and major depressive disorder were significantly less common among religious [patients], who were also less likely to become depressed over time.<sup>65</sup>

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<sup>61</sup>Eckersley, R. ‘Failing a Generation: The Impact of Culture on the Health and Well-Being of Youth’ (1993) 29 Suppl. 1 *Journal of Paediatrics and Child Health* S16.

<sup>62</sup>Bergner, R.M. ‘Therapeutic Approaches to Problems of Meaninglessness (1998) 52 *American Journal of Psychotherapy* 72, 73.

<sup>63</sup>Chamberlain, K. & Zika, S., ‘Religiosity, Meaning in Life, and Psychological Well-Being’ in Schumaker (ed) 138, 139.

<sup>64</sup>Hughes, S. 1982 *The Christian Counsellor’s Pocket Guide*, Kingsway Publications Eastbourne, England, 23.

<sup>65</sup>Koenig, H.G. ‘Religion and Mental Health in Later Life’ in Schumaker (ed), 177, 184.

Belief in an afterlife may help some people endure adverse circumstances; and suffering can be viewed as having a purpose:

Belief in an afterlife involving the promise of bliss can offset some of the adversity faced by people ... suffering can be more readily endured if it is viewed as short-lived, a moment in time compared to eternity ... suffering can be viewed as having a purpose; it may be part of God's will ... to teach us the value of perseverance ... a belief that God is watching and knows about our sufferings may make them more endurable ... a belief in a responsive God, one who hears and will eventually respond to prayer, may pull some people through adverse life circumstances ... religions provide idealistic role models such as Job in the Bible. These figures endure enormous suffering, but do not resort to suicide ... These features of religion are not meant to be an exhaustive list of life-saving beliefs, but they do provide examples of how a few core beliefs might be enough to reduce suicide.<sup>66</sup>

Social support which may occur incident to pastoral counselling is often useful:

There are [various] ways in which religiosity might affect depression levels ... The social cohesiveness hypothesis contends that a religion offers social support from religion-based social networks. Such support includes emotional, cognitive and material benefits that can lower the risk of depression.<sup>67</sup>

### **3.10 The vulnerability of depressed people**

Depression can render a person vulnerable. 'Depression is a major risk factor for suicide',<sup>68</sup> and 'depression, by its nature often leaves [a person] with a pessimistic view of the future and their chances of recovery'.<sup>69</sup> 'A depressed person often becomes withdrawn and isolated. This can seriously compromise their desire and ability to seek appropriate care'.<sup>70</sup>

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<sup>66</sup> Stack, S. 'Religiosity, Depression and Suicide' in Schumaker, J.F. (ed) 1992 *Religion and Mental Health* Oxford University Press, New York, 87, 89-90.

<sup>67</sup> Stack, 93. See also White, S.A. et al 'Christians and Depression Attributions as Mediators of the Depression-Buffering Role of Christian Social Support 22 *Journal of Psychology and Christianity* 49, (2003).

<sup>68</sup> *NHMRC Guidelines*, 66.

<sup>69</sup> *Ibid* 92-93.

<sup>70</sup> *Ibid* 42.

Similarly, the *APA Guideline* states that ‘unfortunately, features of major depressive disorder may include poor motivation, pessimism over the effectiveness of treatments, decrements in cognition such as attention or memory, decreased self-care, and possibly intentional self-harm’.<sup>71</sup>

Depression can impair the ability of a person to make balanced judgments: ‘those in psychological distress are often the least able to make balanced judgments’.<sup>72</sup> Further, a depressed client may have limited knowledge of the nature of depression or the treatments for it. In relation to the patients of doctors it has been noted that ‘the patient ... might be completely unaware of the issues to which his or her mind should be addressed’.<sup>73</sup>

## **Conclusion**

The thesis does not argue that clergy who provide pastoral counselling for depression owe a duty of care regarding clients with minor instances of ‘depression’, even where symptoms are not merely transitory.

Rather, depression has been defined in this chapter as ‘major depressive disorder’ and ‘bipolar disorder’ by reference to the classificatory system used by the American Psychiatric Association’s *DSM-IV-TR*.

The *NHMRC Guidelines* also use this classificatory system. Most people with bipolar disorder also experience major depressive symptoms. In practice, a person with bipolar disorder may be unlikely to attend counselling.

Clergy could not reasonably be expected to diagnose depression. However this will not preclude a duty of care when providing pastoral counselling for depression - should they do so they will have concluded that the client is depressed.

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<sup>71</sup> *APA Guideline*, 8.

<sup>72</sup> *Parliamentary Debates (Hansard)* Psychologists Bill, Second Reading, 19 April 1989, Mr Collins, Minister for Health and Minister for Arts, 6796-6797.

<sup>73</sup> *Rosenberg v Percival* (2001) 75 ALJR 734 per Kirby J at 758.

The main treatments for depression are anti-depressant medication or cognitive behavioural therapy in the case of major depressive disorder, and other pharmacological treatments in the case of bipolar disorder.

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Having defined depression in this chapter, in the next chapter 'pastoral counselling for depression' will be defined.

## Chapter 4

### PASTORAL COUNSELLING FOR DEPRESSION

#### Introduction

This chapter defines ‘pastoral counselling for depression’. The purpose of doing so is to specify the type of communication examined by the thesis.

The thesis is not about pastoral counselling in general, nor all forms of counselling for depression which might be undertaken by clergy, but rather situations where clergy undertake the task of solving the problem of a client’s depression through pastoral counselling:

We are not talking about typical pastoral counseling or typical religious counseling ... We are concerned with a situation ... where [clergy] ... take on the ... task of providing the ... treatment and ... care of the severely mentally ill. That is not your typical religious counseling.<sup>1</sup>

In developing a definition of ‘pastoral counselling for depression’ by clergy, numerous descriptions of ‘counselling’, ‘psychotherapy’ and ‘pastoral counselling’ have been considered.

Given the absence of consensus concerning definition of the different kinds of counselling activity, however, there is scope for choice as to definitions used by the thesis. It is ultimately for the thesis to make such a choice:

There are no widely agreed upon definitions of the different kinds of counselling activity ... Terms such as ‘counselling’ and ‘psychotherapy’ are notoriously ambiguous and are sometimes used interchangeably.<sup>2</sup>

[There are] divergent and competing views concerning what counseling is and what its practitioners ought to do. It has been suggested that there are as many schools of counselling as there are counselors ...<sup>3</sup>

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<sup>1</sup>Counsel for the plaintiff in *Nally*, quoted in Weitz, 169-170.

<sup>2</sup>Woodhouse, J. et al 1999 *Enquiry into the Anglican Counselling Centre: A Report from the Standing Committee* Anglican Church Diocese of Sydney, 37. The author thanks Mr Philip Gerber for provision of a copy of this report.

<sup>3</sup>Van Hoose W.H. & Kottler J.A. 1978 *Ethical and Legal Issues in Counseling and Psychotherapy* Jossey-Bass Publishers, 8.

## 4.1 Some descriptions of counselling

Research has not revealed any judicial definition of counselling in Australia. The parliament of New South Wales permits persons to call themselves ‘counsellors’ without meeting any particular requirements.<sup>4</sup>

The *Family Law Act 1975* (Cth) makes reference to forms of counselling,<sup>5</sup> however ‘counselling’ is not defined therein.<sup>6</sup>

Parker, of the University of New South Wales School of Psychiatry, stated in *Dealing with Depression: A Commonsense Guide to Mood Disorders*:

There are many techniques and applications for counselling. Much counselling focuses on problem solving. The counsellor may, therefore, be of particular help in listening to a wide range of issues, clarifying and ranking key problems, identifying those that may require or benefit from action, encouraging the individual to act and then considering the results of such actions ... Counsellors may range from those who are very directive to those who encourage patients to determine their own options.<sup>7</sup>

In *Basic Types of Pastoral Care and Counseling* the ‘uniqueness’ of pastoral counselling is described by reference to the following indicia:

[T]he training of clergy in religion; [the] ‘premise that spiritual growth is an essential objective’; [the fact that clergy are] ‘expected, and hopefully trained to use the resources of their religious tradition as an integral part of their counselling’; ‘the fact that pastors are part-time counsellors with a variety of other functions’; [the fact that] ‘ministers tend to be perceived as religious authority figures’; [the fact that clergy] ‘usually do not charge for counselling’.<sup>8</sup>

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<sup>4</sup> See section 5.5.

<sup>5</sup> Section 16C(1) states that ‘counselling for marital breakdown’ is ‘counselling’ to ‘assist the parties to a marriage and their children to adjust to the consequences of marital breakdown. Section 62A (a) refers to ‘the counselling of people in relation to matters affecting children. Section 62B(1) says that ‘counselling for Part VII orders is counselling to assist children and parties to proceedings under this Part to adjust to the consequences of orders under this part’.

<sup>6</sup> See Section 60D ‘Defined expressions’ - counselling is not defined.

<sup>7</sup> Parker, 2002, 104.

<sup>8</sup> Clinebell, H. 1984 *Basic Types of Pastoral Care and Counseling* Abingdon Press, Nashville, 67-71.

According to one survey, *Basic Types of Pastoral Care and Counseling* was at one time the most frequently recommended book on pastoral counselling in the US.<sup>9</sup> It is apparently of some influence in Australia, being on the reading list for a course offered by the Australian College of Theology.<sup>10</sup>

Reverend Dr Peter Powell, Principal of the Pastoral Counselling Institute in Sydney, has noted the distinctive nature of pastoral counselling:

Who the counsellor is, where counselling takes place, whether fees are charged, the type of room used ... are all facets of the issue of context. How both the counsellor and the client understand that context affects the nature of the counselling. Various professional disciplines are now involved in counselling and, although there is usually much common ground in terms of counselling theory, each brings a distinctive context to the counselling process. Social workers work out of social theories, psychologists from various psychological theories and psychiatrists from a medical model. Similarly, pastoral counsellors work out of the context of the life and witness of the people of faith, with particular understandings of the nature and meaning of behaviour; consequently, pastoral counselling is a distinctive form of counselling.<sup>11</sup>

It has also been said of pastoral counselling:

Pastoral counseling is both a specialized form of pastoral care and a specialized form of counseling. It should be set apart from other pastoral contacts by means of specific appointments and meetings that are held in a consistent and appropriate setting. Pastoral counseling is not appropriately done in hallways, doorways or in the narthex before the worship service. Not all pastor-parishioner conversations regarding parishioner concerns are pastoral counseling. Pastoral counseling, like any specialized relationship, requires boundaries that protect its special purposes ...<sup>12</sup>

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<sup>9</sup> Based on a survey of 119 seminaries the 1966 edition of Clinebell's book *Basic Types of Pastoral Care and Counseling* which has a slightly different title, *Basic Types of Pastoral Counseling*, was found to be the most frequently recommended book on pastoral counselling - see Haugk, K.C. & Hong, B.A. 'Pastoral Care and Counselling: A Survey of Recommended Readings' (1975) 14 *Journal of Religion and Health* 58, 60.

<sup>10</sup> It is on the reading list for the course 'Foundations of Christian Counselling': see *Undergraduate Manual 2002*, 117.

<sup>11</sup> Powell, P, 2001 *An Introductory Model for a Theory and Practice of Pastoral Counselling*, 3; unpublished paper.

<sup>12</sup> Benner, D.G. 1998 *Strategic Pastoral Counseling* 5th printing Baker Books, Grand Rapids, Michigan, 21.

The above comment is from the US. Nonetheless, it is along similar lines to Dr Powell's comment. The same US author distinguishes pastoral counselling from pastoral care activities such as visiting the sick, attending the dying and comforting the bereaved:

Pastoral counseling is ... an activity of pastoral care, though it differs from ... pastoral care activities in several ways ... pastoral counseling typically has more of a problem focus, that is, something in the life or experience of the parishioner ... for which he or she seeks help ... whereas in other pastoral-care activities biblical precepts are appropriately brought immediately into the relationship by the pastor, in pastoral counseling the use of the Bible is usually not appropriate until the pastor has heard the parishioner's story. This process takes more time than is usually available in brief pastoral care relationships'.<sup>13</sup>

The Psychotherapy and Counselling Federation of Australia ('PACFA') is an umbrella organisation comprising affiliated professional psychotherapy or counselling associations in Australia. The Counselling and Psychotherapy Association of New South Wales ('CAPA') is a member of PACFA. Both PACFA and CAPA state:

Psychotherapy and Counselling are Professional activities that utilise an interpersonal relationship to enable people to develop understanding about themselves and to make changes in their lives. Professional psychotherapists and counsellors work within a clearly constructed, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intrapsychic, or personal nature ... Professional Psychotherapy / Counselling utilises Counselling, Psychotherapeutic, and Psychological theories [and] requires an in-depth training process ... Professional Counselling ... may involve work with current problems, immediate crisis or long-term difficulties. Depending on the nature of the difficulties, the work may be short-term or long-term ... Although Psychotherapy and Counselling overlap considerably there are also some differences. The work with clients may be of considerable depth in both modalities, however the focus of Counselling is more likely to be on specific problems or changes in life adjustment. Psychotherapy is more concerned with the restructuring of the personality or self.<sup>14</sup>

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<sup>13</sup> Benner, 15.

<sup>14</sup> [www.pacfa.org.au](http://www.pacfa.org.au) and [www.capa.asn.au/](http://www.capa.asn.au/).

Despite the comment in the above passage that ‘Psychotherapy and Counselling are professional activities’, the thesis addresses the important question of whether clergy who are non-professional counsellors owe a duty of care should they provide pastoral counselling for depression.

A document entitled *Enquiry into the Anglican Counselling Centre: A Report from the Standing Committee* describes ‘general counselling’, ‘clinical counselling’ and ‘specialised psychotherapy’ as follows:

**General Counselling** is counselling which focuses on assisting people to deal more effectively with issues, difficulties and challenges that arise during the normal course of relationships and personal development. It is generally time-limited and focuses on support and coping strategies, development of personal or interpersonal skills, problem-solving and goal-attainment. General Counselling has a predominant focus on present difficulty or distress and present and future strategies for life and should not be involved in detailed exploration of past experience or in seeking deep emotional expression or understanding.<sup>15</sup>

**Clinical counselling** employs a similar range of counselling skills, but is a more specialised and more specific activity undertaken with clients who are experiencing more serious and/or more persistent difficulties. Clinical counselling may involve exploring, challenging or confronting unhelpful patterns of belief or behaviour and may involve more difficult emotional material.<sup>16</sup>

**Specialised psychotherapy** is psychotherapy that deals with longstanding behavioural and emotional difficulties, or with identifiable psychiatric conditions, and may involve the exploration and release of emotion, the identification and exploration of past causal or traumatic events or experiences. It seeks to bring about change in psychological or personality functioning.<sup>17</sup>

There are ‘many scores’ of definitions of psychotherapy,<sup>18</sup> hence:

The goals and responsibilities of the psychotherapist are so broadly and vaguely defined that it has been said that his profession is one ‘without a specific role function’ ...<sup>19</sup>

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<sup>15</sup> *Supra* n. 2, 37-38; bold type in original.

<sup>16</sup> *Ibid* 38

<sup>17</sup> *Ibid* 38.

<sup>18</sup> Jackson, S.W. (1999) *Care of the Psyche: A History of Psychological Healing* Yale University Press, New Haven, 5.

<sup>19</sup> Karasu T.B. ‘Ethical Aspects of Psychotherapy’ in Bloch, Sidney & Chodoff, Paul (eds) 1991 *Psychiatric Ethics*, 2nd edn Oxford

According to Parker, 'psychotherapy' is:

[A] non-physical treatment whereby the therapist adopts a particular structure (for example, analytic, interpersonal, cognitive, cognitive-behavioural) to address symptoms and/or personality problems experienced by an individual.<sup>20</sup>

The Australian Association of Spiritual Care and Pastoral Counselling is a member of PACFA. It says of pastoral counsellors:

Pastoral counsellors help people with a wide range of difficult life problems both by direct counselling and by supportive activities, in a variety of contexts ... They are particularly sensitive to spiritual and existential issues in counselling ... Their approach to therapy integrates both psychological and theological perspectives. The Association's 35 members are trained in critical social theory, practical theology and the philosophy of ethics, as well as the psychological foundations of counselling, including the approaches associated with the major schools of psychotherapy. Individual practitioners employ varying counselling types.<sup>21</sup>

This comment is only of background relevance as the thesis concerns clergy who have not been trained in counselling.

## **4.2 Defining pastoral care**

'Pastoral care' for the purposes of the thesis is defined as communication by clergy consisting of discussion, for example discussion of depression, asking questions, listening, and / or the provision of empathy. Pastoral care may include an attempt to bring temporary comfort or relief to the other person, for example by providing empathy or listening to the other person.

Pastoral care does not involve an attempt by the cleric to solve the problem of depression or other serious temporal problem, (unless the attempt consists only of referral of the other person to another practitioner), in the sense of eliminating or substantially reducing the depression or problem on an ongoing basis. It would not be appropriate to apply the postulated duty of care to pastoral care as defined herein.<sup>22</sup>

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University Press, 135, 139.

<sup>20</sup> Parker, 2002, 131.

<sup>21</sup> [www.pacfa.org.au](http://www.pacfa.org.au) Member Associations - AASCPC.

<sup>22</sup> See further Appendix B, section B.1.

### 4.3 Defining pastoral counselling

The definition of ‘pastoral counselling’ is no more a matter of consensus than the definition of ‘counselling’. For example, an editor of *The Journal of Pastoral Care* seemed to view the task of defining pastoral counselling as exceedingly difficult:

We are still discussing it, and perhaps always will be. Who is a pastoral counsellor?<sup>23</sup>

‘Pastoral counselling’ is for the purposes of the thesis communication between a cleric and a client occurring during one or more scheduled sessions with a problem solving focus that consists of provision of advice or some other attempt to solve a client’s problem or problems. Pastoral counselling is not pastoral care activity such as visiting the sick, attending the dying or comforting the bereaved. The ‘pastoral’ nature of pastoral counselling is for the purposes of the thesis described by reference to the following indicia:

- (1) The cleric is non-professional counsellor;
- (2) It is undertaken free of charge by the cleric;
- (3) Attempts to solve the client’s problems are wholly or primarily based on religion;
- (4) The client may anticipate or desire that the counselling will be based on religion;
- (5) It may include as one of its objectives the spiritual welfare of the client;
- (6) It does not involve detailed exploration of past experience, the seeking of deep emotional understanding, or attempts to restructure the personality or self of the client;
- (7) It is short-term.

For the purposes of the thesis, a ‘cleric’ means a person appointed, ordained, licensed or otherwise authoritatively empowered by a church for religious service, and who, if providing counselling at all, is a ‘non-professional counsellor’, as that term is defined herein. ‘Clergy’ will be used as a synonym for ‘preachers’, ‘ministers’, ‘pastors’, ‘reverends’, ‘priests’ and similar titles. This definition is limited to Christian clergy.

‘Non-professional counsellor’ means in the thesis a person who provides counselling on a casual or irregular basis only, and who does not possess secular qualifications, training or competence in counselling, psychotherapy, psychology, psychiatry, medicine or the management of depression or other mental or emotional problem.

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<sup>23</sup>Patton, J.H. Editorial ‘Who is a Pastoral Counsellor?’ (1986) 40 *Journal of Pastoral Care* 289, 289.

#### 4.4 Defining ‘pastoral counselling for depression’ by clergy

‘Pastoral counselling for depression’ by clergy is for the purposes of the thesis:

(1) Communication consisting of an attempt to solve the problem of the client’s depression in the sense of eliminating or substantially reducing the depression on an ongoing basis, not merely to provide temporary comfort or relief from the depression;

(2) Which is made within one or more scheduled sessions; where the primary purpose of scheduling the session or sessions is to solve the problem of the client’s depression;

(3) Where the cleric perceives the client to be suffering from depression,<sup>24</sup> either in the sense of major depressive disorder or bipolar disorder, or in the sense of serious depression if the cleric is not aware of those more precise diagnostic categories.

(4) Where such communication consists of provision of advice or a suggestion as to action for the client to take for the purpose of solving the problem of the client’s depression, consisting of advice or a suggestion to study a religious text, request help from God through prayer, attend church, engage in altruistic activity or to believe in God, or provision of information to the effect that these measures may be effective in solving the problem of depression;

and / or

(5) Some other attempt to solve the problem of the client’s depression, consisting of the teaching of religious ideas to the client with a view to having the client accept the ideas and for that reason recover from depression, or praying aloud with the client for the client’s depression to be removed, provided that the communication undertaken is presented to the client as offering a means of solving the problem of the client’s depression.

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<sup>24</sup>From the time the appointment is scheduled, or, (if the session was scheduled by the client and some other person apart from the cleric such as a secretary or a different cleric) from the outset of the first session, or from some point within the sessions prior to making an attempt to solve the problem of the client’s depression.

Which is 'pastoral' in that:

- (1) The cleric is a non-professional counsellor;
- (2) It is undertaken free of charge by the cleric;
- (3) It is based wholly or primarily based on religious ideas;
- (4) The client may anticipate or desire that the counselling will be based on religion;
- (5) The counselling may have as an additional objective the client's spiritual welfare;
- (6) It does not involve detailed exploration of past experience, the seeking of deep emotional understanding, or attempts to restructure the personality of the client; and
- (7) It is short-term (say, for the purposes of discussion, at least one and up to six sessions of at least one hour in duration on a weekly basis).

#### **4.5 Comments on the definition of pastoral counselling for depression**

It may be useful, for the sake of clarity, to comment on the definition of pastoral counselling for depression. First, not all and perhaps none of the above indicia are unique to clergy. That is of no particular significance. Taken together, the indicia distinguish pastoral counselling from other counselling to a considerable extent.

In any event, the primary purpose of defining pastoral counselling, and more importantly pastoral counselling for depression, is not to distinguish pastoral counselling from other forms of counselling, but to identify the communication investigated by the thesis. Where pastoral counselling is applied to a serious temporal problem such as depression, it is inevitable that there will be some overlap between pastoral counselling and other forms of counselling.

Second, during the 'scheduled session', communication other than that which has been defined as pastoral counselling for depression may occur. For example the cleric and client could exchange comments concerning the weather. There might also be discussion of the client's problems, discussion of the client's depression, or provision of empathy. There may also be attempts by the cleric to solve problems other than the client's depression, whether contributing to the client's depression or not. Such attempts are not pastoral counselling for depression for the purposes of the thesis.

Third, it could be said that the definition of pastoral counselling should have included the sort of communication to which reference was just made. The response to that is that there is an absence of consensus within the counselling field as to the meaning of counselling, therefore the definition of a pastoral counselling involves a choice which it is for the thesis to make.

Fourth, it could be said that some clergy could incorporate psychological ideas into their counselling; that some clergy might charge a fee for counselling; that clergy may provide advice for depression outside of a scheduled session; or that many or most clergy do not provide counselling within a scheduled session.

This does not mean the definition of pastoral counselling for depression is unsuitable. The thesis is not about whether clergy ought to provide pastoral counselling for depression as defined herein, nor the extent to which they do.

Fifth, defining short-term counselling as one to six sessions of an hour in duration is not arbitrary. It has been said in the US, in relation to all types of counselling that:

[T]he fact remains that counselors spend on average only five to six hours counseling most individuals ... and many encounters are limited to a single session. Even people who have agreed to long-term therapy often stop coming after a few sessions.<sup>25</sup>

There is paucity of relevant Australian research. There does not seem to be reason to suppose that the situation is greatly different in Australia.

#### **4.6 Defining informal pastoral counselling for depression**

The thesis concerns pastoral counselling for depression, as defined above. 'Informal pastoral counselling for depression' is defined for the purposes of the thesis as communication which would meet the definition of pastoral counselling for depression if it took place in a session scheduled for the primary purpose of solving the problem of depression and if it was of at least one hour in duration and confined to one to six sessions on a weekly basis.

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<sup>25</sup>Stone, H.W. (ed.) 2001 *Strategies for Brief Pastoral Counseling* Ausburg Fortress Minneapolis, 5.

Informal pastoral counselling for depression is thus impromptu pastoral counselling for depression, any one episode of which may be of lesser duration than one hour, where there may be only a single instance, or an indefinite number of instances extending over a period of weeks or months or longer.

Unlike pastoral care as defined herein, informal pastoral counselling for depression involves an attempt to solve the problem of the client's depression in the sense of eliminating or substantially reducing the depression on an ongoing basis, such an attempt not consisting of mere referral of the client to another practitioner.

## **Conclusion**

The term 'counselling' is notoriously ambiguous and there is an absence of any real consensus within the counselling field as to its meaning. There is also only limited consensus concerning the definition of 'pastoral counselling'.

Definition of 'pastoral counselling for depression' is therefore to a considerable extent a matter of choice, and is merely a label for the type of communication investigated by the thesis. It is for the thesis to determine the type of communication investigated.

Whatever definition of counselling activity is used, whether a duty of care exists, and the degree of care required if there is a duty of care, will be decided through application of the law of negligence to the type of communication delineated by the definition, not by the definition itself.

'Pastoral counselling for depression' by clergy has been to a large extent distinguished from other forms of counselling activity in this chapter. Where pastoral counselling is applied to a serious temporal problem such as depression, it is inevitable that there will be some overlap between pastoral counselling and other forms of counselling.

The task of the thesis is not to compare and contrast pastoral counselling for depression with other counselling activity, but to apply the law of negligence to pastoral counselling for depression.

The definition of ‘pastoral counselling for depression’ does not imply a conclusion that all counselling by clergy conforms to that definition - on the contrary, individual approaches will vary.

‘Pastoral care’ and ‘informal pastoral counselling for depression’ have also been defined, and have been distinguished from pastoral counselling for depression and from each other.

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Now that the introductory tasks of defining depression and pastoral counselling for depression have been completed, some preliminary legal points will be considered in the next chapter.

## Chapter 5

### PRELIMINARY LEGAL POINTS

#### Introduction

This chapter addresses a number of background legal considerations. Some pertain to the religious context in which pastoral counselling for depression is provided, and some relate to the law of negligence. First, some aspects of the *CLA* are considered.

#### 5.1 The *CLA*

The *CLA* was partly based on a document entitled *Review of the Law of Negligence: Final Report* ('*Review of the Law of Negligence*'), prepared for the Commonwealth Government.<sup>1</sup>

Following the collapse of the HIH insurance company and the events of 11 September 2001, the *CLA* was passed in response to insurance and legal issues confronting health care workers and other potential defendants:

The New South Wales Government has taken the lead in responding to ... the particular hardships faced by the New South Wales community, the most litigious in Australia ...<sup>2</sup>

The *CLA* applies to negligence claims except those which are excluded from its operation. A case involving pastoral counselling for depression is not within the categories of case that have been excluded.<sup>3</sup>

'The [*CLA*] does not provide a general statement of the circumstances in which [a] relationship ... gives rise to a duty of care. To this extent, the common law will continue to apply to determine whether a duty of care may arise'.<sup>4</sup>

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<sup>1</sup>Commonwealth of Australia, 2002 *Review of the Law of Negligence: Final Report*, 237-240: 'Definitions'.

<sup>2</sup>*Parliamentary Debates (Hansard)* Civil Liability Amendment (Personal Responsibility) Bill, Second Reading, 19 November 2002, Mr Egan, Treasurer, Minister for State Development, 6896, 6897. See also Morris, L. 'Insurance crisis menaces more health workers' *Sydney Morning Herald* 7 June 2002: 7; Metherell, M. & Crichton, S. 'Doctors urged to stay with UMP' *Sydney Morning Herald* 12 June 2002: 7.

<sup>3</sup>Section 3B of the *CLA* states the *CLA* applies to civil liability claims except claims involving acts done with the intention to cause injury or death, dust diseases, smoking of tobacco, motor vehicle accidents, workers compensation, and claims under several other statutes of no relevance to churches or clergy.

<sup>4</sup>Villa, D. 2004 *Annotated Civil Liability Act 2002 NSW* Law Book Co., Sydney, 24.

The meaning of some sections of the *CLA* is unclear. This leaves scope for courts to develop the law, but creates uncertainty:

Few court decisions have yet arisen other than on damages assessment ... and there is an element of guesswork as to the meaning and effect of some of the legislative changes.<sup>5</sup>

Reference to principles governing the interpretation of Acts may help to reduce such uncertainty, and is made in the next section.

## **5.2 Interpretation of the *CLA***

The *Interpretation Act 1987* (NSW) governs the interpretation of Acts. It provides:

In the interpretation of a provision of an Act or statutory rule, a construction that would promote the purpose or object underlying the Act or statutory rule (whether or not that purpose or object is expressly stated in the Act or statutory rule or, in the case of a statutory rule, in the Act under which the rule was made) shall be preferred to a construction that would not promote that purpose or object.<sup>6</sup>

The fact that the *CLA* was passed to reduce the perceived hardships faced by potential defendants in New South Wales does not mean that in every instance where the meaning of the *CLA* is unclear, the uncertainty should be resolved in a way which would favour potential defendants.

This is because the purpose of the *CLA* was to provide potential defendants with some relief, not to completely eliminate civil liability.

The *Interpretation Act* also provides that other material may be used to confirm the meaning of a provision of an Act, or to interpret the provision if its meaning is ambiguous or obscure, if its ordinary meaning is manifestly absurd or is unreasonable.<sup>7</sup>

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<sup>5</sup>Dietrich, J. 'Duty of Care under the 'Civil Liability Acts'' (2005) 13 *Torts Law Journal*, 17, 18.

<sup>6</sup>Section 33.

<sup>7</sup>Section 34 (1) (a) and (b) (i) and (ii).

The *Interpretation Act* specifies various types of other material that may be used to interpret an Act. This material includes any relevant report of a committee of parliament or of either house of parliament before the provision was enacted or made, and the second reading speech of an Act.<sup>8</sup>

Judgments of a court are not mentioned in the *Interpretation Act* as being among the material that may be considered in the interpretation of a provision of an Act. Nor are reports prepared for the federal government. The list of such material that may be considered is inclusive, not exhaustive.

Thus it could be argued that the *Review of the Law of Negligence*, and definitions by courts of terms used by the Act might be of some relevance to its interpretation, although such material would not be conclusive.

Relevant aspects of the *CLA* will be identified at various points in the thesis. In the section that follows, reference is made to the ‘good samaritan’ provision of the *CLA*.

### **5.3 Section 57 of the *CLA* - good samaritans**

The *CLA* provides that a ‘good samaritan’ is not liable for any act or omission done in an emergency when assisting a person apparently injured or at risk of injury.<sup>9</sup> It is submitted that this would not, in general, apply to pastoral counselling for depression, as the requisite state of emergency would be lacking.

Prima facie it would apply to a cleric who seeks to assist a suicidal person about to harm themselves, unless negligence on the part of the cleric in providing counselling could be said to have caused the risk of suicide.<sup>10</sup> There is nothing in the second reading speech of the *CLA* which might support a different conclusion.

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<sup>8</sup>Section 34 (2) (c) and (f).

<sup>9</sup>Section 57 (1). A ‘good samaritan’ is defined in section 56 as a person who in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured.

<sup>10</sup>Section 58(1) states that the protection given to good samaritans ‘does not apply if it is the good samaritan’s intentional or negligent act or omission that caused the injury or risk of injury in respect of which the good samaritan first comes to the assistance of the person’. Section 27 of the *Health Care Liability Act 2001* (NSW) exempting medical and health care practitioners from civil liability for emergency assistance would not apply to clergy as they are not within the definition of such practitioners in section 4 of that Act.

## 5.4 Section 61 of the *CLA* - community work

Section 61 provides that a volunteer does not incur personal civil liability regarding ‘community work’ performed in good faith organised by a community organisation.

‘Community organisation’ means a body corporate, an authority of the State, or a church or other religious organisation.<sup>11</sup> ‘Work’ is defined as including any activity.<sup>12</sup> ‘Community work’ is defined as work that is not for private financial gain, and which is done for a charitable, benevolent, philanthropic, sporting, educational or cultural purpose.<sup>13</sup> Speaking of the meaning of ‘charitable purpose’, Villa stated:

[It is] a well recognised concept in the law of trusts, and is generally said to consist of the relief of poverty, the advancement of religion, the advancement of education, and any other purposes beneficial to the community. It extends to the ... relief of those who are physically weak, disabled or helpless, including the mentally ill ...<sup>14</sup>

The law of trusts is not conclusive of the *CLA*’s interpretation. Regardless, it could be argued that pastoral counselling for depression is done for a charitable, benevolent or philanthropic purpose and is therefore community work, and thus a cleric who provides such counselling could not incur any personal civil liability.

If that argument was accepted, however, then a medical practitioner who provided free medical services organised by a community organisation could also never be personally liable, since those services could also be viewed as being performed for charitable, benevolent or philanthropic purposes. This would appear to be a radical departure from the common law which could not have been intended.

Moreover, it could be argued that the purpose of pastoral counselling for depression, which seeks to solve the medical problem of depression, is primarily medical, not charitable, benevolent or philanthropic. The better view, therefore, is that section 61 of the *CLA* is inapplicable to pastoral counselling for depression.

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<sup>11</sup> Section 60 (1) (b).

<sup>12</sup> Section 60.

<sup>13</sup> *Ibid.* Community work includes work declared by the regulations to be community work but does not include work declared by the regulations not to be community work - *ibid.* The *Civil Liability Regulations 2003* do not indicate which activities are or are not community work, as at 31 March 2005.

<sup>14</sup> Villa, 285, citations omitted.

## 5.5 Exemption of clergy from registration requirements

‘The trend apparent in statute law is a relevant matter in considering the state of development of the common law’.<sup>15</sup> Although the *Psychologists Act 1989* (NSW) requires the registration of psychologists, there are no such requirements regarding clergy. In fact clergy have been deliberately exempted from those requirements:

Those in psychological distress are often the least able to make balanced judgments. Registration would provide some protection since the public would be able to identify persons with approved psychological qualifications and experience. One of the difficulties with legislation in this area ... has been to formulate an acceptable definition of the range of practices that a psychologist undertakes without impeding the work of persons in allied professions or services. Where State legislation has attempted to regulate psychological practices, a large number of exemptions have generally been required for specific categories of persons such as counsellors and ministers of religion ... The bill will not attempt to control unregistered persons using psychologist techniques under other titles unless such persons imply they are psychologists ... the government originally proposed to introduce controls on the use of hypnosis through the mechanism of the psychologists registration legislation ... after further consideration ... it is felt that the present standards of those using hypnosis are satisfactory and that there is little or no evidence of malpractice in this area to merit the imposition of controls.<sup>16</sup>

An example of the exemptions for clergy is found within the Victorian *Psychological Practices Act* (1965), which provided for the registration of psychologists to protect the public from unqualified psychologists and certain practices which included Scientology and hypnotism, on the grounds that those practices were a ‘threat to the community’.<sup>17</sup>

Section 2 (3) of that *Act* exempted clergy:

This Act does not apply to anything done by any person who is a priest or minister of a recognized religion in accordance with the usual practice of that religion.

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<sup>15</sup> *Jones v Bartlett* (2000) 75 ALJR 1 per Gummow and Hayne JJ at 29.

<sup>16</sup> *Parliamentary Debates (Hansard)* Psychologists Bill, Second Reading, 19 April 1989, Mr Collins, Minister for Health and Minister for Arts, 6796-6797.

<sup>17</sup> See New South Wales Anti-Discrimination Board 1984 *Discrimination and Religious Conviction*, The Board, Sydney, 211. In 1982 the provisions of the Act which applied to Scientology were repealed, the Scientology church having been exempted from the Act in 1973 upon being registered under the *Marriage Act 1961* (Cth). Similar South and Western Australian legislation restricting the practice of Scientology was repealed in 1973 - *id.*

The purpose of the *Psychologists Act* 2001 (NSW) was merely to remedy shortcomings of the 1989 *Act*. Its second reading speech does not further reveal the legislative attitude towards counselling by clergy.<sup>18</sup>

The question is whether parliament's deliberate exemption of clergy from registration requirements tells against imposing a common law duty of care where they provide pastoral counselling for depression.

Requiring clergy to undertake years, or even a few months, of academic training in order to become registered is a quite different matter to imposing a common law duty of care, and probably far more burdensome than the burden of complying with the degree of care that the common law might impose on them.

Moreover, parliament's decision not to regulate hypnotists suggests that parliament will not regulate clergy unless there is evidence of widespread negligence by clergy. This does not mean that if there are isolated examples of negligence the common law should not provide a remedy for individual plaintiffs. Doing so would not require any reformulation of law, merely the application of existing negligence law.

In *Hollis v Vabu Pty Ltd* five members of the Court stated:

Reliance was placed on the fact that the New South Wales parliament had considered the question of change to the law in relation to liability for collisions between courier cyclists and others but had not enacted any legislation ... It was submitted that ... this Court should defer to that legislative inactivity. It is one thing to say ... that the common law may develop by analogy to the enacted law. It is another proposition that the common law should stand still because the legislature has not moved. Nevertheless, this proposition might have some attraction if the Court were contemplating the reformulation of basic doctrine ... However ...

The decision applies existing principle ... there is no reason for this Court to decline to [apply] principle ... The legislature may enact some larger or different reform. But in the circumstances of this litigation ... there is no occasion for deference by the judicial branch of government to the legislative branch.<sup>19</sup>

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<sup>18</sup> See *Parliamentary Debates (Hansard)* Psychologists Bill (No 2), Second Reading, 4 September 2001, Mr McManus, Parliamentary Secretary on behalf of Mr Knowles, Minister for Health, 16350-16353. Section 3 indicates its object is to 'protect the health and safety of members of the public by providing mechanisms to ensure that psychologists are fit to practice (sic).'

<sup>19</sup> *Hollis v Vabu Pty Ltd* (2001) 75 ALJR 1356 per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1369.

It is therefore submitted that the mere fact that parliament has exempted clergy from the registration requirements of psychologists, and not imposed any other registration requirements on clergy, does not mean that courts should not impose a common law duty of care on clergy where they provide pastoral counselling for depression.

## 5.6 Novelty of pastoral counselling liability

A case involving the potential liability of clergy for pastoral counselling for depression would not fall squarely within an established category, and in that sense is novel.<sup>20</sup>

Five members of the Court have stated that the novelty of a case, of itself, is 'of no particular significance. The common law consists of judicially formulated principles and, necessarily, there is always a first formulation'.<sup>21</sup> Moreover, the law of negligence has been imposing liability in new situations for decades, and even doctors and lawyers were not always subject to present standards:

Not much is said about them in the reports until comparatively late in our law, perhaps because it was not until then that these professions attained social dignity by measures taken to eliminate quacks in the one case and swindlers in the other.<sup>22</sup>

## 5.7 Contractual relationship

The existence of a contract does not preclude the existence of a duty of care under the law of negligence.<sup>23</sup> In fact professional-client relationships fit more comfortably within the law of negligence than contract.<sup>24</sup> Accordingly this thesis considers a possible duty of care in negligence. Contracts between clergy and clients will not generally exist where counselling is provided for free.<sup>25</sup>

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<sup>20</sup>This is the meaning of 'novel' used by, for example, Brennan J in *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 481 when his Honour stated: 'in my view ... the law should develop novel categories of case incrementally and by analogy with established categories'.

<sup>21</sup>*Northern Territory v Mengel* (1994) 185 CLR 307 per Mason CJ, Dawson, Toohey, Gaudron and McHugh JJ at 339. See also *Candler v Crane, Christmas & Co.* [1951] 2 KB 164 per Denning LJ at 178: 'I wish never to hear this objection [novelty] again'.

<sup>22</sup>Winfield, P 'The History of Negligence' (1926) 42 *Law Quarterly Review* 184, 187.

<sup>23</sup>*Voli v Ingelwood Shire Council* (1963) 110 CLR 74 per Windeyer J at 84 (Dixon CJ and Owen J agreeing): an architect 'must use due care. If he [or she] fails in these matters and the person who employed him thereby suffers damage, he is liable ... This liability can be said to arise either from a breach of contract or in tort'; *Bryan v Moloney* (1995) 182 CLR 609 per Mason CJ, Deane & Gaudron JJ at 619-620 (quoting Windeyer J's statement with approval).

<sup>24</sup>*Astley & Others v Austrust Ltd* (1999) 197 CLR 1 per Callinan J at 51.

<sup>25</sup>This may be due to absence of consideration or intention to create legal relations, both necessary elements of a contract - see

## 5.8 Disclaimer of a duty of care

It is conceivable that a cleric could seek exemption from a duty of care by disclaiming a duty of care. Such a disclaimer could be made within a contract (which will not usually exist) or in the absence of a contract.

Barwick CJ stated in relation to disclaimers:

I doubt whether the speaker may always exempt himself from the performance of the duty by some express reservation at the time of his utterance. But the fact of such a reservation, particularly if acknowledged by the recipient, will in many instances be one of the circumstances to be taken into consideration in deciding whether or not a duty of care has arisen and it may be sufficiently potent in some cases to prevent the creation of the necessary relationship ... Whether [the reservation prevents the creation of the necessary relationship] must, in my opinion, depend upon all the circumstances of and surrounding the giving of the information and advice.<sup>26</sup>

It is arguably contrary to the public interest to allow clergy who provide pastoral counselling for depression to exclude the taking of reasonable care, and courts should be very reluctant to give effect to such disclaimers, contractual or otherwise.

This is because depressed clients may be unable to make balanced or informed decisions regarding the management of their depression.<sup>27</sup>

Some US commentators have argued that imposing a duty of care will lead to clergy disclaiming liability to clients and thus impairment of their relationships with clients.<sup>28</sup> However Australian clergy would be unwise to rely on disclaimers for the reason just given, thus the question of impairment of relationships by disclaimers should not arise.

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Carter J.W. & Harland D.J. 2002 *Contract Law in Australia* 4th edn Butterworths, Australia, 97 and 163. If no fee is paid there will generally be no consideration flowing from the client. Payment may help to establish intention to create legal relations.

<sup>26</sup> *MLC* per Barwick CJ at 570.

<sup>27</sup> See section 3.10.

<sup>28</sup> Eg. Bartel, 544.

## 5.9 Voluntary assumption of risk

It could be argued, based on the fact that ‘public policy is not ordinarily opposed to a party agreeing to accept, with full knowledge, a substandard skill from another’,<sup>29</sup> that clergy who draw attention to relevant limitations in their training or competence should not be subject to a duty of care, since clients voluntarily proceed with a practitioner without the qualifications of mental health professionals, and are free to accept or reject the cleric’s counselling.<sup>30</sup>

This argument is flawed for three reasons. First, agreement to accept a service which is in some respect deficient is not agreement to accept service which is in *every* respect deficient.<sup>31</sup> It may not be reasonable to expect clergy who provide pastoral counselling for depression to have the same level of competence as mental health professionals, but that does not mean that nothing can be expected of them.

Second, in order to assume a risk plaintiffs must not only have knowledge of a condition creating danger, but full and clear appreciation of the hazards inherent therein:<sup>32</sup>

To satisfy the test of voluntary assumption of risk, it must be shown that the claimant fully comprehended the extent of the risk and chose to accept or ignore it.<sup>33</sup>

Most depressed clients could not have such a ‘full and clear appreciation’ due to their compromised ability to make judgments and their less than complete knowledge of depression.<sup>34</sup>

Third, if freedom to accept or reject counselling precluded liability then by the same reasoning all clients of professionals would be without remedy for negligence, since clients are always free to accept or reject professional opinion.

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<sup>29</sup>Fleming, 123.

<sup>30</sup>This argument was made in *Nally, Religious Freedom Reporter* 91 (May 1985), per Kalin J (trial judge) at 95.

<sup>31</sup>Fleming, 336.

<sup>32</sup>*Ibid* 337.

<sup>33</sup>*Woods v Multi-Sport Holdings Pty Ltd* (2002) 76 ALJR 483 per Kirby J at 504.

<sup>34</sup>See section 3.6.

## 5.10 Freedom of speech and religion

Despite the controversy in the US on whether imposing a duty of care where clergy provide counselling is inconsistent with religious freedom or church-state separation,<sup>35</sup> and the presence of section 116 in the Commonwealth Constitution,<sup>36</sup> these matters are no more relevant to the duty of clergy who provide counselling for depression than to the duty of medical practitioners. The same applies to ‘freedom of speech’.

There is no freedom of speech in Australia, unless seen as residual to all restrictions to which speech is subject. Although ‘freedom of speech’ has been said to be ‘a highly valued element in our society’,<sup>37</sup> ‘of cardinal importance’,<sup>38</sup> and ‘an essential element’,<sup>39</sup> free speech does not mean free speech, but ‘freedom governed by law’.<sup>40</sup>

As Gaudron J says, ‘recourse to the general law reveals that ... speech ... may be regulated and ... severely restricted’.<sup>41</sup> Similarly, ‘religious conviction is not a solvent of legal obligation’.<sup>42</sup> Religious conduct is subject to:

[O]rdinary laws i.e. ... laws which do not discriminate against religion generally or ... particular religions or ... conduct of a kind which is characteristic only of religion.<sup>43</sup>

Negligence law is ordinary law in this sense.

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<sup>35</sup> See generally the articles referred to in section 2.4.

<sup>36</sup> Section 116 inter alia prohibits the Commonwealth from legislating to establish any religion or to prohibit the free exercise of any religion. In the US opponents of clerical counselling liability have generally drawn greater succour from the establishment clause of the First Amendment rather than the free exercise clause. The s. 116 establishment clause has been given a radically different interpretation to the First Amendment establishment clause - see *Attorney General (Vic) Ex rel Black v The Commonwealth* (1981) 146 CLR 559. There is no possibility of the s. 116 establishment clause being used by a court to deny clerical counselling liability. Space limitations preclude further comment on s.116 or the First Amendment.

<sup>37</sup> *Adelaide Company of Jehovah's Witnesses v Commonwealth* (1943) 67 CLR 116 per Latham CJ at 127.

<sup>38</sup> *Gallagher v Durack* (1983) 152 CLR 238 per Gibbs CJ, Mason, Wilson and Brennan JJ at 243.

<sup>39</sup> *ACTV v The Commonwealth* (1992) 108 ALR 577 per Mason CJ at 597.

<sup>40</sup> *Jehovah's Witnesses* per Latham CJ at 126-127.

<sup>41</sup> *ACTV* per Gaudron J at 656.

<sup>42</sup> *Scientology* per Mason ACJ and Brennan J at 136.

<sup>43</sup> *Id.* Similarly see *Jehovah's Witnesses* per Latham CJ at 131, per Rich J at 147-148, per Starke J at 155, per McTiernan J at 157, per Williams J at 159-160; *Kruger v The Commonwealth* (1996) 190 CLR 1 per Gaudron J at 134; *Ermogenous v Greek Orthodox Church of SA Inc* (2002) 76 ALJR 465 per Kirby J at 480: ‘courts will reject the notion that religious organisations, as such, are somehow above secular law and exempt from its rules’.

Paradoxically, it has been said by three justices of the Court that secular courts may not adjudicate on the truth or falsity of religious belief.<sup>44</sup> This is inconsistent with the authority just cited.

For example if a cleric informs a client that adherence to a certain belief is ‘the best’ or ‘the only’ way to cure depression then the accuracy of that statement may be subject to judicial scrutiny.<sup>45</sup> It is because even very ‘religious’ counselling can affect temporal welfare that courts may examine counselling by clergy.

The basis for legal intervention has been explained by J.S.Mill. According to Latham CJ, Mill’s discussion of liberty ‘is widely accepted as a weighty exposition of principle’.<sup>46</sup> Mill stated:

Acts, of whatever kind, which without justifiable cause, do harm to others, may be, and in the more important cases absolutely require to be, controlled ... As soon as any part of a person’s conduct affects prejudicially the interests of others, society has jurisdiction over it ...<sup>47</sup>

Or, as Brennan J has said, ‘in law there is no absolute freedom to do anything that might affect another’.<sup>48</sup>

It is apparent from the authorities cited above in this section that the distinction between proprietary and other rights<sup>49</sup> is inapplicable regarding enforcement of the common law (as opposed to church law). The common law certainly does not protect only proprietary interests or rights.

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<sup>44</sup> *Scientology* by Mason ACJ and Brennan J at 134 expressly adopting a comment by Douglas J in *United States v Ballard* (1944) 322 US 78 at 86-87: ‘Men ... may not be put to the proof of their religious beliefs’. See also *Scientology* per Murphy J at 150: ‘The truth or falsity of religions is not the business of officials or the courts’.

<sup>45</sup> It is not alleged that clergy in Australia make such comments, they are given as illustrations only.

<sup>46</sup> *Jehovah’s Witnesses* at 131.

<sup>47</sup> Mill, J.S. 1864 *On Liberty* 3rd edn Longman Green, London 101 and 135.

<sup>48</sup> *Theophanous v Herald Weekly Times* (1993) 182 CLR 104 at 146.

<sup>49</sup> Referred to in the Preface.

### 5.11 *Clark v Roman Catholic Archdiocese of Brisbane*

In *Clark v Roman Catholic Archdiocese of Brisbane* Williams J of the Queensland Supreme Court held that clergy cannot be sued for negligent spiritual advice.<sup>50</sup> *Clark* involved allegedly erroneous advice about the circumstances in which Roman Catholics can take communion.

Such advice is quintessentially or purely spiritual,<sup>51</sup> easily distinguishable from advice concerning, for example, how to solve the problem of depression. *Clark* is therefore not authority contradicting the imposition of a common law duty of care where clergy provide counselling to solve the problem of depression, pastoral or otherwise.

### 5.12 The ‘consensual compact’ entered into by church members

Not all clients of clergy will be members of the cleric’s church, but even where the client is a member this will not tell against duty where pastoral counselling for depression is provided. In *Clark*, Williams J held that the defendant did not owe the plaintiff a common law duty.<sup>52</sup>

His Honour reached this conclusion partly on the basis that members of churches enter into a ‘consensual compact’ to which they are bound by their shared faith, citing comments by Priestley JA (with whom Hope AJA agreed) in *Scandrett v Dowling*.<sup>53</sup>

It is, however, essential to note that not all matters will remain in the area of consensual compact without legal effect.<sup>54</sup> *Scandrett* was about ordination of women. *Clark* concerned when Catholic priests could give communion to non-Catholics. These matters, being spiritual, stay within the ‘consensual compact’, but issues as to the quality of counselling for depression are medical and legal and do not remain therein.

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<sup>50</sup> [1998] 1 Qd R 26.

<sup>51</sup> It may be difficult to conclude that a belief is ‘purely’ spiritual, as most doctrines of some religions may have *some* application to temporal life. The phrase ‘purely spiritual and theological rules’ was used by Kirby J in *Ermogenous* at 479.

<sup>52</sup> At 33-34.

<sup>53</sup> (1992) 27 NSWLR 483 per Priestley JA at 513: ‘the parties to the consensual compact upon which the plaintiffs rely are bound to it by their shared faith, not the availability of the secular sanctions of the judgments, orders or decrees of State courts of law ....’

<sup>54</sup> *Id.*: ‘I do not think that the claims made *in this case* [emphasis added] get out of the area of the consensual compact ...’.

In the US it has been argued that clergy should not be subject to duties when advising members of their church.<sup>55</sup> Even if valid, this argument lacks universal application, because clergy may counsel non-members.

It is not valid, however. There is if anything more, not less reason to impose a duty of care in relation to members, since church members may be more vulnerable than the general public.<sup>56</sup> Further, whether a person is a ‘member’ of a church is not always clear. Making liability dependent on membership distracts attention from important issues, such as counselling quality.

### 5.13 Difficulty in proving causation

In *Nally* the majority of the Californian Supreme Court asserted that ‘the ... connection between defendants (sic) conduct and Nally’s suicide was tenuous at best’ and that this told against imposing a duty of care.<sup>57</sup>

While there would be no point in imposing a duty if breach could *never* cause compensable harm, this reasoning should not be applied in Australia, even though McHugh J has cited difficulty in proving causation as telling against duty.<sup>58</sup> Difficulty in proving causation in medical negligence claims has not prevented imposition of duty on medical practitioners. As Barwick CJ stated:

[T]he loss and damage must be causally related to the want of care. Thus it will not be recoverable if it flows entirely from an independent exercise of judgment on the part of the claimant ... It is no doubt easier to conclude that the advice caused the loss in the case of technical advice such as legal or medical advice, though even in these cases there are often considerable areas in which the person advised has room for personal judgment ... in less technical matters the area for such judgment and decision may be greater and the question of causation correspondingly more difficult. *But these difficulties would not seem to be to be a reason for denying the cause of action.*<sup>59</sup> (emphasis added)

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<sup>55</sup> Eg. Cupp, 977-985.

<sup>56</sup> For example an expert witness in *Nally* stated ‘[Nally] had been unduly influenced by members of the Church. This undue influence contributed to his inability ... to seek adequate treatment’ - 204 Cal. Rptr. 303 (Cal. App. Dist. 1984), 316-317 (Dr S. Wilson psychiatrist).

<sup>57</sup> 253 Cal. Rptr. 97 (Cal. 1988), 108.

<sup>58</sup> For example in *Esanda* McHugh J noted that ‘the client’s conduct is the primary cause of the plaintiff’s loss, the auditor’s role is secondary’ and said this was a factor against imposition of duty (at 286).

<sup>59</sup> *MLC* per Barwick CJ at 568.

## 5.14 The act / omission distinction

Regarding pastoral counselling for depression, a want of care might consist of provision of counselling that has the potential to exacerbate the client's depression.<sup>60</sup> A want of care could also consist of an omission, such as an omission to refer the client to a general practitioner or mental health professional, which may lead to unnecessarily prolonged depression.

In Australia the view is sometimes expressed that 'the common law does not ordinarily impose liability for omissions'.<sup>61</sup> However where clergy provide pastoral counselling for depression and omit to refer the client, the conduct is not merely an omission, but an omission in the course of a larger, positive act, namely the provision of pastoral counselling for depression. Such an omission is therefore potentially actionable:

[W]hatever its further scope, Lord Atkin's formulation in *Donoghue v Stevenson* includes 'an omission in the course of positive conduct ... which results in the overall course of conduct being the cause of injury or damage'.<sup>62</sup>

Thus the fact that 'the common law does not ordinarily impose liability for omissions' does not mean clergy who take the positive action of providing pastoral counselling could not owe a duty of care extending to the taking of positive steps to benefit a client.

This is not the same as imposing a duty to help another person in the absence of some pre-existing relationship. Thus if a cleric encounters a depressed person they may choose to do nothing without fear of liability. A cleric would not owe a duty of care to a depressed person merely because they know the person is depressed, or because the person requests assistance.<sup>63</sup>

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<sup>60</sup> See section 15.10.

<sup>61</sup> *Modbury* per Gleeson CJ at 169.

<sup>62</sup> *Sutherland Shire Council* per Deane J at 501.

<sup>63</sup> Clergy may be distinguished from medical practitioners. The latter group are expected by their profession to respond to requests to aid a person in need of urgent attention: see *Lowns v Woods* (1996) ATR 81-376 where Kirby P and Cole J, (Mahoney JA dissenting) held that a general practitioner had a duty to provide emergency assistance on request when there was no impediment to him doing so, irrespective of the absence of a previous relationship with the plaintiff.

### **5.15 The act / word ‘distinction’**

The distinction between acts and words, to the extent that one exists, is not relevant to pastoral counselling for depression. Barwick CJ stated:

I have been unable to find any ... radical difference between the performance of physical acts or omissions and an utterance by way of information and advice as would require the common law to deny a cause of action in the case of the latter while conceding it in the case of the former.<sup>64</sup>

His Honour also asked rhetorically:

Would it not be strange indeed if the physical harm done to a person by careless medical attention of a physical kind was in any different case to financial loss caused by careless or erroneous medical advice, the parties standing in each case in the same relationship ...<sup>65</sup>

This passage refers to financial loss from careless medical advice, but applies, it is suggested, equally if not with even more force to physical harm caused by careless medical advice. Fleming makes the same point even more clearly:

Obviously, a doctor must observe the same professional skill and care in relation to medical advice ... as to physical treatment like massage or surgery.<sup>66</sup>

The same should apply to pastoral counselling for depression. It would be strange if doctors could be liable for careless words, but clergy could avoid liability because the negligence consisted of words, or lack of words.

### **5.16 The duty of care does not begin when a session is scheduled or at the outset of the first session**

It is not argued that the postulated duty of care arises, if it arises at all, from the scheduling of a session for the purpose of solving the problem of the client’s depression.

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<sup>64</sup> *MLC* at 568.

<sup>65</sup> *Ibid* 567.

<sup>66</sup> Fleming, 192.

A depressed person could schedule an appointment with a mental health professional or the secretary thereof for a date, say, one week later. It is most unlikely that a mental health professional would have a duty of care to take reasonable measures to protect the person from the risks of depression during that time or to refer the client to another practitioner who could provide more immediate assistance, unless perhaps the mental health professional provided some advice or counselling over the telephone.

*A fortiori*, a cleric would not owe a duty of care to take steps to solve the problem of a client's depression merely because a session was scheduled for that purpose.

Nor is it argued that the postulated duty of care begin at the outset of the first scheduled session. This is in contrast to the duty of care of mental health professionals. Such practitioners may be obliged to take positive steps from the outset of an appointment, for example to ask questions of the client in order to reach a diagnosis.

#### **5.17 A duty, if any, to attend is separate to the postulated duty of care**

If a cleric schedules a counselling session with a client and for some reason does not keep it, the client could be disappointed by the cleric's non-attendance, and become more vulnerable to loss or injury. For example the client could conclude that no one cares about them and lose hope, and thereby be at greater risk of a suicide attempt. This would not be a balanced reaction, however 'those in psychological distress are often the least able to make balanced judgments'.<sup>67</sup>

Whether a cleric would have a legal duty to attend an appointment scheduled with a client, or to contact the client in advance or as soon as possible after the scheduled time, and explain why attendance was not possible is beyond the scope of the thesis.

If there was a duty to attend it should be viewed as separate to any duty of care to exercise reasonable care in relation to the pastoral counselling for depression itself. The existence of the former would not mean the existence of the latter and vice versa.

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<sup>67</sup> *Parliamentary Debates (Hansard)* Psychologists Bill, Second Reading, 19 April 1989, Mr Collins, Minister for Health and Minister for Arts, 6796-6797.

## **5.18 The duty of care does not extend to all communication**

The postulated duty of care is not a duty to take care in relation to every form of communication within a scheduled session in which pastoral counselling for depression is provided.

Clergy may engage in communication within a session in which pastoral counselling for depression is provided, which does not constitute pastoral counselling for depression, such as comment about the weather, or provision of empathy to the client. It is not argued that this communication attracts the postulated duty of care.

Alternatively a cleric may attempt to deal with other problems in a client's life, such as a drug or alcohol problem, which may be contributing to the depression. This is not pastoral counselling for depression as defined herein. It is not suggested that attempts to assist a client with a drug or alcohol problem would attract the postulated duty of care.

## **5.19 A duty to avoid breaching client confidentiality or sexual misconduct is separate to the postulated duty of care**

There are various forms of potentially harmful words or conduct which, although they could occur in relation to counselling, are not pastoral counselling for depression.

Such forms of conduct have been identified within church codes of conduct for clergy, and codes of ethics for pastoral counsellors,<sup>68</sup> which require clergy or counsellors to avoid disclosing confidential client information,<sup>69</sup> sexual activity with clients, exploitation of the client in any way, and conflicts of interest.

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<sup>68</sup> *Integrity in Ministry - A Document of Principles and Standards for Catholic Clergy and Religious in Australia* (1999), National Committee for Professional Standards, 1999, a committee of the Australian Catholic Bishops Conference and the Australian Conference of Leaders of Religious Institutes, publisher not indicated ('*Integrity in Ministry*'), 11-12; the *American Association of Pastoral Counsellors Code of Ethics* at [www.aapc.org.ethics.htm](http://www.aapc.org.ethics.htm).

<sup>69</sup> For example the *American Association of Pastoral Counsellors Code of Ethics* says 'we do not disclose client confidences to anyone, except as mandated by law' - Principle IV, D.

For example a code of conduct from one denomination says that clergy should:

[Avoid] as far as possible close business relationships with persons to whom one is providing intensive and/or one-to-one pastoral ministry ... exercis[e] prudent judgment before ministering in a situation where a conflict of interest may arise, eg. when offering counselling, advice or spiritual direction to more than one person from the same family ... it is essential that clergy ... seek professional advice and review of pastoral relationships where [they sense themselves to be] sexually attracted to the person [they] are supporting.<sup>70</sup>

There may be legal requirements to avoid such conduct (whether there are or not is beyond the scope of the thesis). For example in relation to confidential information:

It can also be argued that wrongful disclosure of confidential information by a minister or priest represents a breach of the duty of care owed by the minister or priest to the parishioner and is therefore actionable in negligence.<sup>71</sup>

Legal duties, if any, to refrain from divulging confidential information, or from other forms of questionable behaviour mentioned above, could be viewed as an aspect of an overall duty of care to exercise reasonable care when providing pastoral counselling for depression, if such a duty of care arose.

However duties would be, it is suggested, more appropriately viewed as separate to the postulated duty of care. Even if it was not reasonable to impose a duty of care regarding the pastoral counselling for depression, it may be reasonable to expect the cleric not to disclose confidential information or exploit the client.

Thus a requirement to avoid disclosing confidential information revealed during counselling is best viewed as separate to a duty of care to the postulated duty of care, just as a duty to avoid carelessly bumping into the client and knocking them over, or a duty, if any, to warn the client of a slippery floor would also be part of a separate duty.

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<sup>70</sup> *Integrity in Ministry*, 11-12.

<sup>71</sup> Fisher & MacFarlane, 280.

There is authority of the Court which suggests that a defendant can owe more than one duty of care to a plaintiff.<sup>72</sup> This suggests that the above method of analysing the duties which a cleric might owe a client is valid.

## 5.20 The term ‘special relationship’ is question-begging

Judges of the Court have from time to time used expressions such as ‘sufficiently close relationship’,<sup>73</sup> or ‘special relationship’,<sup>74</sup> to describe the type of relationship which will attract a duty of care.

Barwick CJ, though, said the relationship out of which a duty of care arises is sometimes styled ‘special’ merely ‘for emphasis as well as for lack of suitable nomenclature’.<sup>75</sup> Gleeson CJ described the term ‘special relationship’ as ‘question-begging’.<sup>76</sup> The thesis therefore does not use these terms.

## 5.21 Proximity

Use of the concept of proximity as the determinant of whether a duty of care arises has been abandoned by the Court. A majority of the Court have stated that the concept of proximity is not relevant ‘whether it is expressed as the ultimate test of a duty of care, or of one of a number of stages in an approach towards a conclusion on that issue’.<sup>77</sup>

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<sup>72</sup>In *Cole v South Tweed Heads Rugby League Club* (2004) 217 CLR 469 the Court considered whether a licensed football club owed a duty of care to a patron who consumed alcohol to the point of intoxication to protect her against the risks of consumption of alcohol. It was obvious that the club as an occupier of premises owed a duty of care to take reasonable care for the physical safety of people, such as the plaintiff, who entered the premises. However Gleeson CJ did not approach the case as though the duty of care issue was already resolved and the only remaining duty question was degree of care required. Instead his Honour considered whether there was ‘a duty to take reasonable care to protect a consumer of alcohol against the risk of physical injury resulting from consumption of alcohol’ - at 475. It is plain from comments by Gummow and Hayne JJ in their joint judgment that they regarded the duty to protect the plaintiff from the risks of alcohol consumption as separate to the duty of care which the defendant owed as an occupier - at 491. Callinan J also approached the case on the basis that the two duties were separate - at 504.

<sup>73</sup>Eg. *Perre* per Gummow J at 253-254.

<sup>74</sup>Eg. *Tepko Pty Ltd v Water Board* (2001) 75 ALJR 775 per Gleeson CJ, Gummow & Hayne JJ at 784.

<sup>75</sup>*MLC* at 569.

<sup>76</sup>*Modbury* at 170.

<sup>77</sup>*Sullivan v Moody* (2001) 75 ALJR 1570 per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1578.

## 5.22 Complexity of policy decisions

Where a decision to impose a duty of care would involve complex policy considerations, a court may leave the decision to do so to legislatures:

The greater the social, economic and political implications of any alteration of decisional authority, the more likely it is that a court will leave the change to a legislature.<sup>78</sup>

This is not an argument against imposing a duty of care, but only one against liability being initiated by courts. While there are numerous policy issues, as will be discussed in chapter sixteen, it does not follow that the policies are so complex that courts must leave the matter to the legislature.

## 5.23 The difference between principle and policy

The difference between a principle and a policy has not been clarified by the Court:

I have yet to hear a compelling account of the difference between principle and policy ... One High Court Justice suggested to me that the difference was that principles apply throughout the law while a more local concern, say that which underpins a barrister's immunity, is best described as 'policy'. But it seems to me that, if you choose a wider focus, the latter immunity could just as easily be couched in terms of the wide 'principle' of protecting the fearless administration of justice. Another High Court Justice suggested to me that ... a reason proffered by counsel might be described at that stage as a policy argument but that once accepted as a convincing concern by an appellate court it could then be described as a 'legal policy or value'.<sup>79</sup>

While it is useful to note that the difference has not been clarified as reference is made herein to both principle and policy, the issue is not of great moment to the thesis.

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<sup>78</sup> *Brodie v Singleton Shire Council* (2001) 75 ALJR 992 per Kirby J at 1034.

<sup>79</sup> Stapleton, J. 'The golden thread at the heart of tort law: Protection of the vulnerable' (2003) 24 *Australian Bar Review* 135, 135-136.

## Conclusion

The *CLA* does not provide a general statement of the circumstances in which a duty of care will arise. To this extent, the common law will continue to apply.

The better view is that pastoral counselling for depression is not ‘community work’ within the meaning of section 61 of the *CLA*, and therefore the protection afforded to volunteers who engage in community work does not apply. The fact that clergy have been exempted from the licensing requirements applicable to psychologists does not mean courts should decline to impose a duty of care.

Disclaimer of a duty of care by the cleric will not be effective in precluding a duty of care regarding pastoral counselling for depression. The concept of ‘voluntary assumption of risk’ is not relevant to consideration of whether clergy owe a duty of care for pastoral counselling for depression, nor are concepts of freedom of religion and speech relevant.

*Clark v Roman Catholic Archdiocese of Brisbane* is not authority contradicting the imposition of a common law duty of care where clergy provide counselling for depression, religious or otherwise. The ‘consensual compact’ entered into by church members will not preclude the postulated duty of care.

Difficulty which clients may have in proving a causal link between breach of the proposed standard and a suicide attempt should not be considered relevant to whether a duty of care exists where clergy provide pastoral counselling for depression.

It is necessary to distinguish between omissions in the absence of any positive action, and omissions in the course of some larger activity, such as pastoral counselling for depression. Thus the fact that the common law does not ordinarily impose liability for omissions does not mean clergy who take the positive action of providing pastoral counselling could not owe a duty of care extending to the taking of positive steps to benefit a client.

The ‘distinction’ between acts and words is not relevant to the thesis. There is no radical difference between physical acts or omissions and words which would require the common law to deny a cause of action in the case of the latter while conceding it in the case of the former.

The postulated duty of care does not begin at the time a session is scheduled, nor at the outset of the first session. A duty, if any, to attend an appointment scheduled with a client is separate to any duty of care to exercise reasonable care in relation to the pastoral counselling for depression. The existence of the former would not mean the existence of the latter and vice versa.

The postulated duty of care is not a duty to take care in relation to every form of communication within a scheduled session in which pastoral counselling for depression is provided. Clergy may make other comments or give advice within a session in which pastoral counselling for depression is provided, which does not constitute pastoral counselling for depression and to which the postulated duty of care does not apply.

There are various forms of questionable conduct which, although they could occur in relation to a counselling client, do not constitute pastoral counselling for depression.

These include disclosure of confidential information and sexual activity with a client. Whether there are legal requirements or duties to avoid such conduct is beyond the scope of the thesis. Duties, if any, to refrain from these forms of behaviour are best viewed as separate to the postulated duty of care.

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Now that all introductory tasks have been completed, consideration of the duty of care issue can commence in the next chapter. It will be seen that the law of negligence in Australia is of inherent indeterminacy.

## THE INHERENT INDETERMINACY OF NEGLIGENCE LAW

### Introduction

The law of negligence in Australia contains ‘endemic difficulties’<sup>1</sup> and is of ‘inherent indeterminacy’.<sup>2</sup> The Court has indicated there is no majority accepted general approach for determination of whether a duty of care exists:

[N]either proximity nor the categories approach or any synthesis of them has gained the support of a majority of Justices of this Court. Indeed, since the fall of proximity, the Court has not made any authoritative statement as to what is to be the correct approach for determining the duty of care question. Perhaps none is possible.<sup>3</sup>

[A]ny attempt to establish a single general principle of liability for all negligence cases, “which run the gamut from physical injury to emotional distress to varied kinds of economic loss”, will be shown “to be as hopeless as it is unwise”.<sup>4</sup>

[N]o one has ever succeeded in capturing in any precise formula a comprehensive test for determining whether there exists, between two parties, a relationship sufficiently proximate to give rise to a duty of care ...<sup>5</sup>

Not only is there no majority accepted methodology that can be applied to negligence cases generally, but even within a category of case simple formulae appear unavailable.

For example in *Perre v Apand*, a case involving purely economic loss, Gummow J said regarding determination of when a duty of care arises in that category of case, stated:

There is no simple formula which can mask the necessity for examination of the particular facts. That this is so is not a problem to be solved; rather ... “it is a situation to be recognised”.<sup>6</sup>

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<sup>1</sup> *Scott v Davis* (2000) 204 CLR 333 per Gummow J at 421.

<sup>2</sup> *Ibid* 422.

<sup>3</sup> *Perre* per McHugh J at 210.

<sup>4</sup> *Hill v Van Erp* (1997) 188 CLR 159 per Gummow J at 230.

<sup>5</sup> *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1578.

<sup>6</sup> *Perre* per Gummow J at 253, citation omitted.

## 6.1 The relevance of previous cases

No previous Australian case is directly relevant to whether clergy owe a duty of care when providing pastoral counselling for depression although, as will be seen in the next chapter, there may be some directly relevant general principles.

Nor would a case involving pastoral counselling for depression fit squarely within any previous category of case, except to the extent that all negligence cases fall, in a sense, into one large category under the umbrella of Lord Atkin's formulation in *Donoghue v Stevenson*, which was:

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.<sup>7</sup>

Gaudron J described 'the rule expressed in *Donoghue*' as 'the general duty',<sup>8</sup> and Brennan J stated that in *Donoghue* Lord Atkin 'reasoned to a unifying principle which, once articulated, governed the host of cases that followed'.<sup>9</sup>

The identity and significance of relevant factors will be different in different categories of case nonetheless:

The identity and relative importance of the considerations relevant ... will obviously vary in different classes of case ...<sup>10</sup>

Even though negligence cases fall in one sense within one large category, therefore, observing how a factor has been relevant in a past case will not shed conclusive light on whether clergy who provide pastoral counselling for depression owe a duty of care:

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<sup>7</sup> [1932] AC 562 at 580.

<sup>8</sup> *Hawkins v Clayton* (1988) 164 CLR 539 at 594-595.

<sup>9</sup> *Dietrich v The Queen* (1992) 177 CLR 292 at 322.

<sup>10</sup> *Jaensch v Coffey* (1984) 155 CLR 549 per Deane J at 584.

[W]hile the listing of ... factors relevant to the duty issue help unmask the substantive determinations being made by judges in this field, they cannot operate as some sort of mechanical guide as to how a novel case will be decided in future.<sup>11</sup>

As McHugh J indicated, it is necessary to identify principles of general application:

Where ... novel cases arise, the existence of a duty can only be determined by reference to ... principles of general application ...<sup>12</sup>

A majority of the Court later confirmed that ‘the law of tort develops by reference to principles, which must be capable of general application’.<sup>13</sup> According to McHugh J, there are ‘few’ principles of general relevance to duty of care:

[F]ew principles of general application ... can be found in the duty cases.<sup>14</sup>

Consideration of previous cases will therefore focus on what was said which may be of relevance to negligence in general, rather than to its particular application to the facts of those cases. A lengthy excursus into previous duty of care cases would take the thesis well beyond its intended scope while not providing any proportionate assistance in determining whether the postulated duty of care may exist. A commentator has argued that when a novel case arises:

Earlier case law [should] not be pre-classified into ‘pockets’ based on crude factual similarity ... Thus a case involving, say, negligent words, [should] not be pre-assigned to a pocket of precedents relating to ‘liability for negligent statements’ ... Instead it would be considered in light of any case law there might be ... even where the overall factual contexts of such precedents look quite different to the case in hand.<sup>15</sup>

It is one thing not to assign cases to pockets or categories, but another to identify within ‘any case law there might be’ principles of general relevance. Identification of principles of general relevance is needed, and as McHugh J said, there are few of those.

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<sup>11</sup> Stapleton, J. ‘Duty of Care Factors: A Selection From the Judicial Menus’ in Cane, P. & Stapleton, J. 1998 *The Law of Obligations: Essays in Celebration of John Fleming*, Clarendon Press, Oxford 59, 88.

<sup>12</sup> *Crimmins* per McHugh J at 34.

<sup>13</sup> *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1579.

<sup>14</sup> *Id.*

<sup>15</sup> Stapleton, 1998, 90.

## 6.2 Analogy and incrementalism

If a pastoral counselling case arose the plaintiff might assert that the case is analogous to a mental health professional-client relationship and should be examined in that light. Or a defendant could argue that the plaintiff asserted a novel duty which could not by any analogical or incremental approach be established, it having been argued:

The law should develop novel categories of negligence incrementally and by analogy with established categories.<sup>16</sup>

The Australian Law Reform Commission stated:

The pastoral ministry undertaken by clerics is generally accounted as analogous often to that of the therapist or social worker.<sup>17</sup>

It is established that mental health professionals owe a duty of care to their clients.<sup>18</sup> In *Nally Kaufman J* adverted to what he viewed as the close resemblance between ‘therapist-patient’ relationships and the relationship between the defendants and Nally in holding that the defendants had owed a duty of care:

It is black-letter law that one may have an affirmative duty to protect another from harm where a “special relationship” exists ... The critical question, therefore, is whether there existed some special relationship between Nally and defendants which would give rise to an affirmative duty to act ... [here] courts have traditionally looked to relationships where “the plaintiff is typically in some respect vulnerable and dependent upon the defendant who, correspondingly, holds considerable power over the plaintiff’s welfare” ... The special relationship that arises between a patient and his doctor or psychotherapist creates an affirmative duty ... The relation of the non-therapist or pastoral counselor to his counselee contains elements of trust and dependence which closely resemble those that exist in the therapist-patient context ...<sup>19</sup>

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<sup>16</sup> *Sutherland Shire Council* per Brennan J at 481.

<sup>17</sup> The Australian Law Reform Commission Report on privilege, quoted in Fisher & MacFarlane, 278.

<sup>18</sup> See eg. *MLC* per Barwick CJ at 567: ‘It has long been accepted that loss and damage caused by action taken upon careless professional advice ... is recoverable’.

<sup>19</sup> 253 Cal. Rptr. 97 (Cal. 1988), 114-115.

It may therefore seem that consideration of the degree of analogy between the relationships of a cleric who provides pastoral counselling for depression and the client on the one hand, and between mental health professionals and their depressed clients on the other, would be useful.

Similarity between such relationships, however, does not necessarily mean that clergy have a duty of care when providing pastoral counselling for depression. Equally, differences between clergy and mental health professionals do not necessarily mean that clergy do not owe a duty of care:

When a legal rule or result is attached to a certain relationships or phenomena, the perception of similar characteristics in another relationship or phenomenon leads to the attachment of a similar legal rule or result. Unless the analogy is close, the applicability of the legal rule or result to the supposedly analogous relationship or phenomenon is doubtful. It is fallacious to apply the same legal rule or to attribute the same legal result to relationships or phenomena merely because they have some common factors; the differences may be significant and may call for a different legal rule or result. Judicial technique must determine whether there is a true analogy.<sup>20</sup>

The statement that ‘judicial technique must determine whether there is a true analogy’ provides limited guidance for the purposes of the thesis.

Further, while some support has been expressed for an approach whereby the law is developed incrementally and by analogy with established categories,<sup>21</sup> its utility has also been questioned. For example Gummow J remarked:

The case law will advance from one precedent to the next. Yet the making of a new precedent will not be determined merely by seeking the comfort of an earlier decision of which the case at bar may be seen as an incremental development. Such a proposition, in terms used by McCarthy J in the Irish Supreme Court “suffers from a temporal defect - that rights should be determined by the accident of birth”.<sup>22</sup>

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<sup>20</sup> *Dietrich*, 322.

<sup>21</sup> Eg. *Hill* per Dawson J at 178-179, per Toohy J at 189-190; *Perre* per McHugh J at 217; *Crimmins* per Gleeson CJ at 13.

<sup>22</sup> *Perre* per Gummow J at 253-254.

Hayne J agreed with the above statement by Gummow J, and also highlighted the absence of a principle to explain why one case should or should not be viewed as analogous to another:

The incremental approach to ascertaining the existence of a duty of care has ... a temporal consequence. As Gummow J pointed out ... recovery becomes an accident of history dependent upon when, in the development of the common law, the claim falls for consideration ... Further, if the process of finding a duty of care in novel circumstances depends upon drawing analogies with existing cases, there is a question about what it is that makes the case in question sufficiently analogous to past cases to warrant finding a duty. Even incremental steps require reference to general principles. As I have said, however, the search for some unifying principle or principles which will explain why an analogy has been drawn with previous authority in some cases but not others has so far proved unsuccessful.<sup>23</sup>

Gaudron J also questioned the utility of the incremental approach:

[T]here has been some criticism of proximity as a criterion of liability, it having been said, for example by Brennan J in *Hawkins v Clayton* that it lacks the specificity of a precise proposition of law". The same may be said of the proposition that the law should develop incrementally and by analogy.<sup>24</sup>

Fleming found the incremental approach to be unhelpful:

Many judges continue to extol proximity as the self-answering lode-star, though the term obviously lacks definition ... A current formula employed by English courts demanding "foreseeability, proximity and what is fair and reasonable" is no more helpful. Nor is the Australian-inspired prescription ... of "incrementalism". Could not any of the decisions invoking it just as well have gone the other way?<sup>25</sup>

The thesis accordingly does not take an approach based on analogy or incrementalism. It is preferable to proceed by reference to general principles of the law of negligence, rather than by comparing and contrasting clergy who provide pastoral counselling for depression with mental health professionals.

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<sup>23</sup> *Brodie* per Hayne J at 1055.

<sup>24</sup> *Hill* per Gaudron J at 199.

<sup>25</sup> Fleming, 144.

### 6.3 The importance of the circumstances

There is no authority of the Court to suggest the postulated duty of care could never exist. As will be argued in chapter sixteen, there is no policy reason to justify a blanket denial of liability in all cases where clergy provide pastoral counselling for depression. Absolute immunity ‘must satisfy a heavy burden of justification’<sup>26</sup> and ‘is in principle inconsistent with the rule of law but in a few, strictly limited, categories of cases it has to be granted for practical reasons’.<sup>27</sup>

Nor is there authority of the Court to compel a conclusion that a duty of care would always arise. The fact that ‘pastoral counselling for depression’ takes place within a session or sessions scheduled for the purpose of solving the problem of a client’s depression is an insufficient basis on which to impose a duty of care upon personnel who are non-professional counsellors.

Depressed clients are vulnerable,<sup>28</sup> however it is clear that mere vulnerability to damage on the part of a plaintiff, no matter how great, will not create a duty of care. For example risk of quadriplegia did not yield a duty of care in *Agar*.<sup>29</sup>

Nor would a cleric’s knowledge of the client’s vulnerability would not suffice. If this were the exhaustive criterion of a duty to act, legal duty would correspond to moral obligation, which is not the case. For the same reason the fact that a cleric may be able to help the client would not suffice.

The law of negligence does not provide a simple rule for every problem. In *San Sebastian v The Minister*, a case concerned with liability for provision of advice, a majority of the Court quoted without demur a statement made in the Privy Council:

It is not possible to lay down hard and fast rules as to when a duty of care arises in this or any other class of case where negligence is alleged.<sup>30</sup>

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<sup>26</sup> *Giannarelli v Wraith* (1988) 165 CLR 543 per Wilson J at 575.

<sup>27</sup> *Darker v Chief Constable of the West Midlands Police* [200] 4 All ER 193 per Lord Cooke of Thorndon at 202 quoted by Gaudron, McHugh & Gummow JJ in *Brodie* at 1012.

<sup>28</sup> See section 3.10.

<sup>29</sup> See Gleeson CJ at 564; Gaudron, McHugh, Gummow & Hayne JJ at 578-584; Callinan J at 601.

<sup>30</sup> *San Sebastian Pty Ltd v The Minister* (1986) 162 CLR 340 per Gibbs CJ, Mason, Wilson & Dawson JJ at 356 quoting Lord Reid & Lord Morris in *MLC v Evatt* [1971] AC 793 at 810.

Rather, the circumstances of the particular case must be examined in order to decide whether a duty of care exists, except in categories where it is established that a duty of care applies such as ordinary motor vehicle accident cases, where it is recognised that the circumstances are always such as to give rise to a duty of care, or those where immunity from liability always exists:

In deciding whether the necessary relationship exists, and the scope of the duty which it creates, it is necessary for the court to examine closely all the circumstances that throw light on the nature of the relationship between the parties ... None of this process will be necessary if the facts fall into a category which has already been recognized by the authorities as attracting a duty of care, the scope of which is settled - e.g. no trial judge need inquire for himself whether one motorist on the highway owes a duty to another to avoid causing injury to the person or property of the latter, or what is the scope of that duty.<sup>31</sup>

This points away from adopting an approach which does not reflect the circumstances of particular cases where clergy provide pastoral counselling for depression. Such an approach was taken by the majority of the Californian Supreme Court in *Nally*, in which the pastoral nature of the counselling was emphasised, and other facts of the case were overlooked, as seen in section 1.1.

By way of contrast, the Court has made it clear that the facts of each case should be considered. For example in *Smith v Jenkins*, which concerned whether a driver of a motor vehicle which he and his passengers had stolen owed a duty of care to the passengers, Barwick CJ, speaking generally about duty of care, stated:

The duty of care, which is the prerequisite to success in an action of negligence to recover damages for personal injuries, is a duty which the law imposes upon a party by reason of his relationship to another in the circumstances of the case.<sup>32</sup>

*Rootes v Shelton* raised the issue of whether the driver of a motor boat owed a duty of care to a water-skier being towed by the boat. Barwick CJ, with whom McTiernan J agreed, again directed attention to the facts of the particular case:

Whether or not such a duty arises ... must necessarily depend in each case upon its own circumstances.<sup>33</sup>

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<sup>31</sup> *Sutherland Shire Council* per Gibbs CJ at 441-442; Wilson J agreeing.

<sup>32</sup> (1970) 119 CLR 397 at 400. This statement was quoted approvingly by Jacobs J (with whom Stephen and Mason JJ agreed) in *Sydney County Council v Dell 'Oro* (1974) 132 CLR 97 at 118.

<sup>33</sup> *Rootes v Shelton* (1967) 116 CLR 383 at 385.

Owen J expressed the same view in *Rootes*:

Whether in any particular case a duty of care is owed by one participant in a sport to another who is engaged in it depends upon the circumstances of that case.<sup>34</sup>

*Kenny v Good Pty Ltd v MGICAA Ltd* concerned whether real estate valuers who were paid by a bank to value a property owed a duty of care to the bank's mortgage insurer. Gummow J emphasised the importance of close examination of the facts:

In Australia, in accordance with authority in this Court, the determination in such a case as this of the existence and scope of a duty of care requires scrutiny of the precise relationship between the relevant parties.<sup>35</sup>

*Agar v Hyde* involved the potential duty of care owed by members of the board of a rugby union association to players. The same theme was evident in the joint judgment of Gaudron, McHugh, Gummow and Hayne JJ, wherein it was said:

Duties of care are owed to individuals and must be considered in relation to the facts of that individual's case.<sup>36</sup>

In *Hill v Van Erp*, which concerned whether a solicitor owed a duty of care to an intended beneficiary of a will, Dawson J recognised that cases are rarely so simple that consideration of only one factor will permit a conclusion:

One factor alone will rarely lead to a conclusion; the relevant circumstances will usually be more complex than that.<sup>37</sup>

Kirby J, speaking generally about duty of care, summed up the importance of the facts:

[T]he conclusion reached in each case depends upon a thorough understanding of the facts. From the facts is ultimately derived the answer to the question: does the law impose legal responsibility on the defendant ... in the circumstances proved?<sup>38</sup>

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<sup>34</sup> *Ibid* at 396.

<sup>35</sup> *Kenny v Good Pty Ltd v MGICAA Ltd* (1999) 199 CLR 413 per Gummow J at 445.

<sup>36</sup> (2000) 201 CLR 552 per Gaudron, McHugh, Gummow & Hayne JJ at 578.

<sup>37</sup> *Hill* per Dawson J at 183.

<sup>38</sup> *Modbury* per Kirby J at 171.

## Conclusion

Australian negligence law contains ‘endemic difficulties’<sup>39</sup> and is of ‘inherent indeterminacy’.<sup>40</sup> There is no majority accepted general approach regarding duty of care. No previous Australian case is of direct relevance to pastoral counselling for depression.

Reasons for avoiding an approach based on consideration of the degree of analogy between clergy and mental health professionals have been given.

The law of negligence develops by reference to principles of general application. Where a novel case arises, the existence of a duty of care can only be determined by reference to principles of general application, and examination of the circumstances that throw light on the nature of the relationship between the parties.

Few principles of general application to whether or not a duty of care exists can be found in previous cases.

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In the next chapter some of the few principles of general application in relation to duty of care will be considered.

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<sup>39</sup> *Scott* per Gummow J at 421.

<sup>40</sup> *Ibid* 422.

## Chapter 7

### GENERAL PRINCIPLES

#### Introduction

Some of the general principles of the law of negligence are found in the judgment of Barwick CJ in *MLC*. In that case his Honour considered ‘the features of the ... relationship in which the law will import a duty of care in utterance by way of information or advice’.<sup>1</sup>

In this chapter it will be demonstrated that the Court has accepted Barwick CJ’s approach in *MLC*, and argued that it is relevant to pastoral counselling for depression. As will be seen, consideration of the elements of knowledge and reasonableness of reliance are central to that approach.

It will also be argued that even if Barwick CJ’s approach is not seen as being of particular relevance to consideration of whether clergy owe a duty of care for pastoral counselling for depression, questions of reliance would in any event be likely to loom large in that inquiry.

#### 7.1 The Court’s acceptance of Barwick CJ’s approach

Barwick CJ was in the majority of the Court in *MLC*. Subsequent authority of the Court ‘has affirmed the force and effect of what the majority said in *MLC*’.<sup>2</sup>

Barwick CJ’s judgment in *MLC* was not identical to those of the other majority judges.<sup>3</sup> His Honour’s approach has received most support, however. Mason J stated:

I consider that this Court should now adopt Barwick CJ’s statement of the conditions which give rise to a duty of care in the provision of information or advice.<sup>4</sup>

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<sup>1</sup> *MLC* at 571.

<sup>2</sup> *Tepko* per Kirby & Callinan JJ at 802.

<sup>3</sup> See *MLC* per Kitto J at 584-585; per Menzies J at 617.

<sup>4</sup> *Shaddock v Parramatta City Council* (1981) 150 CLR 225 per Mason J at 251 (Aickin J agreeing).

Dawson and Gaudron JJ respectively have noted the acceptance of Barwick CJ's approach:

The ... formulation by Barwick CJ of the circumstances in which liability would be imposed has been accepted in subsequent cases.<sup>5</sup>

[Barwick CJ's approach] which was accepted as correct by Mason J in *Shaddock* ... should ... now be accepted as correct.<sup>6</sup>

It is therefore clear that Barwick CJ's approach has been accepted by the Court.

## 7.2 Why Barwick CJ's approach is relevant

Barwick CJ's judgment in *MLC* is sometimes described as being the foundation for the law of 'negligent misstatement'<sup>7</sup> in Australia, which could suggest it applies only to inaccurate statements. However as his Honour's judgment makes clear, it applies to utterances 'by way of information or advice'.<sup>8</sup>

Barwick CJ's judgment in *MLC* is of general relevance, applying where the advice or information is given in connection with 'some matter of business or serious consequence'.<sup>9</sup> Depression is a serious matter.

His Honour's judgment was therefore not confined to business or professional contexts. Nor was it confined to cases involving purely economic loss.<sup>10</sup>

Therefore Barwick CJ's approach is prima facie directly applicable to pastoral counselling for depression, at least to the extent that the counselling consists of advice or information for depression.

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<sup>5</sup> *Esanda* per Dawson J at 255.

<sup>6</sup> *Tepko* per Gaudron J at 787.

<sup>7</sup> Eg. Katter, N.A. "'Ball Park' Figures and the Ambit of Duty of Care for Negligent Misstatement' (2001) 75 ALJ 427, 431.

<sup>8</sup> *MLC* at 571.

<sup>9</sup> *MLC* at 571.

<sup>10</sup> See eg. *Shaddock* per Murphy J at 255: 'the liability extends to economic as well as non-economic loss'.

Pastoral counselling for depression as defined herein may be viewed as the performance of a service. There is close analogy between cases involving the negligent provision of a service and a case involving the negligent provision of advice or information, sometimes referred to as negligent misstatement, as McHugh J recognised:

A case of negligent performance of a service ... is closely analogous to negligent misstatement.<sup>11</sup>

Moreover, Gummow and Kirby JJ noted analogy between ‘negligent misstatement’ cases and a case where there may be a duty of care to avoid risk of psychiatric harm:

An antecedent relationship between the plaintiff and the defendant, especially where the latter has assumed some responsibility to the former to avoid exposing him or her to a risk of psychiatric harm, may supply the basis for importing a duty of care ... A duty to avert psychiatric harm in these circumstances finds some, necessarily imperfect, analogy in cases of negligent misstatement causing pure economic loss ...<sup>12</sup>

Thus Barwick CJ’s approach in *MLC* is arguably applicable to pastoral counselling for depression. The term ‘assumption of responsibility’ used by Gummow and Kirby JJ is ‘imprecise and beguiling but deceptively simple’.<sup>13</sup> It need not be further pursued, as it is not the basis of Barwick CJ’s approach.

### 7.3 Barwick CJ’s approach

Barwick CJ described the ‘essential elements which the relevant relationship must exhibit’<sup>14</sup> in order for a duty of care to arise for the provision of advice or information:

First of all, I think the circumstances must be such as to have caused the speaker or ... to cause a reasonable person in the position of the speaker to realize that he is being trusted by the recipient of the information or advice ... about a matter upon ... which the recipient believes the speaker to possess a capacity or opportunity for judgment ... the subject matter of the information or advice being of a serious or business nature. It seems to me that it is this element of trust which the one has of the other which is at the heart of the relevant relationship ...<sup>15</sup>

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<sup>11</sup> *Perre* per McHugh J at 229.

<sup>12</sup> *Tame v New South Wales* (2002) 211 CLR 317 per Gummow & Kirby JJ at 398.

<sup>13</sup> *Hill* per Gummow J at 229. According to Toohey & Gaudron JJ the phrase is not ‘free of difficulty’ - *Esanda* at 263.

<sup>14</sup> *MLC* at 571.

<sup>15</sup> *Id.*

Barwick CJ's next statement was similar:

Then the speaker must realize or the circumstances be such that he ought to have realized that the recipient intends to act upon the information or advice in respect of his property or of himself in connexion with some matter of business or serious consequence.<sup>16</sup>

Barwick CJ then stated that the circumstances must be such that reliance would be reasonable, and set out the manner in which the reasonableness of reliance is to be assessed:

Further ... the circumstances must be such that it is reasonable in all the circumstances for the recipient to seek, or to accept, and to rely upon the utterance of the speaker. The nature of the subject matter, the occasion of the interchange, and the identity and relative position of the parties as regards knowledge actual or potential and relevant capacity to form or exercise judgment will all be included in the factors which will determine the reasonableness of the acceptance of, and of the reliance by the recipient upon, the words of the speaker.<sup>17</sup>

It can be seen from the above passages that Barwick CJ emphasised the importance of the circumstances. His Honour also stated that 'the duty will arise out of circumstances which create the requisite relationship'<sup>18</sup> and 'the duty of care, in my opinion, is imposed by law in the circumstances'.<sup>19</sup>

The statements above that the speaker, or a reasonable person in the position of the speaker, must realize that 'he is being trusted' and that the speaker realises or ought to realise 'that the recipient intends to act upon the information or advice' are to a considerable extent coterminous.

They will therefore be treated as synonymous with each other and with the concept of reliance. There is also an issue as to whether knowledge of the client's *intention* to rely on the counselling is required, or whether knowledge of the likelihood of such reliance would suffice. This will be considered in the next section.

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<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Ibid* 569.

<sup>19</sup> *Ibid* 570.

#### **7.4 Knowledge of intended reliance or knowledge of the likelihood of reliance?**

It could be argued that there is a need for care to be taken when pastoral counselling for depression is provided, and this is so whether the cleric realises that the client *intends* to rely on the counselling, or merely that reliance is likely.

There is no directly relevant authority on the point. Its appropriate resolution is therefore a matter of opinion. Of background interest is the fact that in *Tepko*, Kirby and Callinan JJ, with whom McHugh J agreed, said in their joint judgment:

[I]t would be sufficient to establish a duty of care if the defendant knows, or ought to know, that the information is required for a serious purpose, and is *likely to be* acted upon.<sup>20</sup> (emphasis added)

Medical practitioners will not always know that a particular patient *intends* to rely on their advice, but it is not the case that they owe a duty of care only to patients whom they perceive as having that intention.

Adapting Barwick CJ's approach to pastoral counselling for depression, therefore, it should therefore be asked whether the cleric knew or should have known of any likelihood of the client relying on the pastoral counselling for depression, and whether reliance by the client on the counselling, if it occurred, would be reasonable.

It would not be a valuable exercise to specify the meaning of 'likelihood' in terms of a precise percentage probability. Moreover, any such specification would consist of opinion. It is suggested the reliance must be at least a significant possibility, but need not be more likely than not.

#### **7.5 Questions of reliance depend on the facts of the case**

Whether a client is likely to rely on pastoral counselling for depression will depend on the facts of the case. Similarly, if there is such a likelihood, then whether a cleric knows or should have known of that likelihood, and whether such reliance would be reasonable, will also depend on the facts of the particular case. This is suggested by the following statement by four members of the Court:

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<sup>20</sup>*Tepko* at 803.

Any finding about duty of care will often depend upon the evidence which is given at trial. Questions of reliance or knowledge of risk are two obvious examples of the kinds of question in which the evidence given at trial may take on considerable importance in determining whether a defendant owed the plaintiff a duty of care.<sup>21</sup>

This is also clear from Barwick CJ's judgment in *MLC*.

## 7.6 Actual reliance is not required

'Reliance' as a factor which will favour the existence of a duty of care in the context of pastoral counselling for depression is not actual reliance, but rather knowledge by the cleric of the likelihood of reliance on pastoral counselling for depression, or knowledge the cleric should have had of the likelihood of reliance, where such reliance if it occurred would be reasonable, as discussed above.<sup>22</sup>

Actual reliance is relevant to causation, as Gummow J explained:

[R]eliance is not always an essential ingredient for the plaintiff in a negligence case. The primary significance of reliance is in cases of alleged negligent provision of advice or information where reliance aids the formulation of a duty of care and detrimental reliance enters into the question of causation of loss.<sup>23</sup>

## 7.7 Reliance on reliance to establish a duty of care

Speaking generally about the law of negligence, Mason J stated:

Reliance has always been an important element in establishing the existence of a duty of care. It has been suggested that liability in negligence is largely, if not exclusively, based on the plaintiff's reliance on the defendant's taking care in circumstances where the defendant is aware or ought to be aware of that reliance ... And it has certainly been an influential factor in ... confining the class of persons to whom a duty of care may be owed.<sup>24</sup>

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<sup>21</sup> *Agar* per Gaudron, McHugh, Gummow & Hayne JJ at 578.

<sup>22</sup> Section 7.4.

<sup>23</sup> *Pyrenees Shire Council v Day* (1998) 192 CLR 330 per Gummow J at 385-386.

<sup>24</sup> *Sutherland Shire Council* at 462.

There is no need to consider whether there is any inconsistency between Gummow J's statement in the previous section that reliance is 'not always and essential ingredient' and Mason J's comment that reliance 'has always been an important element'. Reliance is plainly of broad-spectrum relevance, as further suggested by the following statement by Brennan J:

Some broader foundation than mere foreseeability must appear before a common law duty to act arises. There must ... be either the undertaking of some task which leads another to rely on it being performed, or the ownership, occupation or use of land or chattels to found the duty ...<sup>25</sup>

Therefore even if the Court's approach regarding provision of advice or information is not seen as particularly relevant to pastoral counselling for depression, questions of reliance would in any event be likely to loom large in considering whether a duty of care was owed.

### **7.8 *Tepko Pty Ltd and others v Water Board***

Barwick CJ's approach has been applied in *Shaddock*, *San Sebastian*, *Sutherland Shire Council*, *Esanda* and *Tepko*.<sup>26</sup> Consideration of the particular applications of Barwick CJ's approach to the facts of those cases is not of direct assistance in determining whether clergy who provide pastoral counselling for depression owe a duty of care.

The most recent of these cases, *Tepko*, in which the full bench of the Court sat, will be considered in this section, however, as background to application of Barwick CJ's approach to pastoral counselling for depression in the next chapter.

The facts were that a property developer, a Mr Neal, wished to subdivide land owned by he and Tepko Pty Ltd, in which he was one of the shareholders. Council approval for the subdivision was subject to the Water Board connecting the land its water supply system. The Water Board agreed to connect the land only if the plaintiffs paid all costs necessary for the connection.

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<sup>25</sup> *Ibid* 478-479.

<sup>26</sup> Katter, 431.

At the same time, Mr Neal took out a bank loan to finance the subdivision. For the purposes of the loan, Mr Neal sought an estimate from the Water Board as to the cost of the connection. The Water Board was not obliged to answer the query and for some time refused to do so.

Mr Neal pressed the Water Board to relax its policy as to the provision of costing information while not informing the Water Board of his dealings with the bank.

The estimated cost was later furnished to the Minister for Natural Resources. Another Minister conveyed the figure to Mr Neal. His financial structure collapsed because of the anticipated costs. The costs estimate, however, was overstated.

There was little disagreement concerning the relevant law. All members of the Court applied Barwick CJ's approach.<sup>27</sup> There was, however, divergence concerning its application to the facts. By a four-three majority the Court held that no duty of care was owed.

Gleeson CJ, Gummow and Hayne JJ, in a joint judgment, held that no duty of care existed because it was not reasonable for Mr Neal to have relied on the Water Board's cost estimate:

[T]he circumstances here were not such as to make it reasonable for Mr Neal to rely upon the "ball-park" figure to meet the Bank's demand for a costings estimate. The identity and relative position between the Board and Mr Neal was one in which the Board plainly was a reluctant participant; the Board did not wish to give Mr Neal information and it resisted giving it until eventually it "caved in". In that difficult situation Mr Neal, at all material times, had access to expert advice, which he utilised. These circumstances and the provisional nature of the estimate eventually provided ... made it unreasonable to posit a duty upon the Board in respect of the use Mr Neal made of the estimate in his dealings with the Bank.<sup>28</sup>

As this passage shows, their Honours placed emphasis on the fact that the plaintiff had access to other advice. Whether it is relevant that a client may have access to other advice, for example from a mental health professional, is considered in the next chapter.

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<sup>27</sup> *Tepko* per Gleeson CJ, Gummow & Hayne JJ at 784, per Gaudron J at 787-788, per Kirby & Callinan JJ at 802 (McHugh J agreeing).

<sup>28</sup> *Ibid* 784.

Gaudron J wrote a separate judgment along the lines of the joint judgment of Gleeson CJ, Gummow and Hayne JJ. Her Honour found there was no known reliance because the defendant had limited knowledge of Mr Neal's financial situation, and the estimate provided was subject to change.<sup>29</sup> In her Honour's view these facts, along with the fact that the plaintiff could have sought other expert advice, made any reliance which occurred unreasonable.<sup>30</sup>

Kirby and Callinan JJ, with whom McHugh J agreed, held that a duty of care had been owed. Like the other judgments, the judgment of Kirby and Callinan JJ involved a close examination of the facts.

In relation to whether the defendant knew or should have known the plaintiff would rely on the information, Kirby and Callinan JJ stated:

Developers would naturally look to the respondent for information with respect to the ... cost of the supply of water to land that developers might wish to subdivide. These would be matters of intense economic interest to the developers, as the respondent would well know ... [the respondent did not have to provide an estimate, however this is] beside the point because in this case the respondent chose, albeit reluctantly, to provide an estimate ... Obstinacy or reluctance could not justify negligence, or negate a duty of care, if it exists, as, in our opinion, it certainly did once the estimate was given. The respondent must have known that the appellant trusted the respondent to give him, if not a precise sum ... at least an order of costs estimate that was not negligently calculated or otherwise carelessly provided. The respondent knew, in fact, one of the purposes for which the appellant sought the information, namely that it would be used in making decisions about whether to seek to develop the land...<sup>31</sup>

Regarding the reasonableness of reliance, their Honours commented:

If the appellant could not rely upon the respondent, upon whom, it might be asked, could he rely for an authoritative and reasonably well-informed estimate of the order of costs? Why should he not rely on the estimate in fact provided, expressed as it was in relatively unqualified terms?<sup>32</sup>

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<sup>29</sup> *Ibid* 789.

<sup>30</sup> *Id.*

<sup>31</sup> *Ibid* 800.

<sup>32</sup> *Ibid* 805.

The divergence between the conclusions of Gleeson CJ, Gummow, and Hayne JJ along with Gaudron JJ on the one hand, and McHugh, Kirby and Callinan JJ on the other, illustrates how different judges can apply the same law to the same facts and reach a different conclusion, and thus provides an illustration of the inherent indeterminacy of the law of negligence in Australia:

[A]ny court of reasonable diversity of opinion must inevitably be sometimes ambivalent on [novel cases], and split decisions in the High Court have manifested instances within the twilight zone where difficulty must inevitably exist.<sup>33</sup>

## **Conclusion**

In *MLC* Barwick CJ stated general principles concerning the features of the relationship in which the law will impose a duty of care for provision of information or advice. The elements of knowledge and reasonableness of reliance are central to that approach.

Barwick CJ's judgment in *MLC* has been accepted by the Court. It was not confined to advice or information provided in business or professional contexts. Nor was it confined to cases involving purely economic loss.

Rather, it is of general relevance, applying where the advice or information is given in connection with some matter of serious consequence. Depression is of serious consequence.

There is analogy, which is arguably close, between provision of a service, such as pastoral counselling for depression, and provision of advice or information. Therefore a case involving pastoral counselling for depression is one in which the approach of Barwick CJ in *MLC* can, and arguably should, be applied.

Adapting Barwick CJ's approach to pastoral counselling for depression, it should be asked whether the cleric knew or should have known of any likelihood of the client relying on the pastoral counselling for depression, and whether reliance by the client on the counselling, if it occurred, would be reasonable.

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<sup>33</sup>Derrington, D. 'Theory of Negligence Advanced in the High Court of Australia' (2004) 78 ALJ 595, 595.

Even if Barwick CJ's approach in *MLC* is not seen as being of particular relevance to pastoral counselling for depression, questions of knowledge and reasonableness of reliance would in any event be of likely importance.

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'Reliance' as a factor which will favour the existence of a duty of care in the context of pastoral counselling for depression is not actual reliance, but rather knowledge by the cleric of the likelihood of reliance on pastoral counselling for depression, or knowledge the cleric should have had of the likelihood of reliance, where such reliance if it occurred would be reasonable.<sup>34</sup> Those questions will be considered in the next chapter.

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<sup>34</sup>Sections 7.3 and 7.4.

## KNOWLEDGE AND REASONABLENESS OF RELIANCE

### Introduction

This chapter considers the elements of knowledge and reasonableness of reliance. A range of circumstances relevant to whether a cleric would know or could reasonably be expected to know of a likelihood of the client relying on pastoral counselling for depression, and whether such reliance would be reasonable, are discussed.

First, it will be seen that the facts that a cleric is a non-professional counsellor or does not profess to be a professional counsellor will not in themselves preclude these elements from arising, and will not in themselves preclude a duty of care.

### 8.1 The non-professional status of a speaker, and the absence of a representation to be professional, does not preclude a duty of care

Barwick CJ's judgment in *MLC* supports the proposition that a speaker's non-professional status in relation to the subject matter of advice or information does not preclude the elements of knowledge and reasonableness of reliance from arising:

In my opinion, the elements of the special relationship to which I have referred do not require either the actual possession of skill or judgment on the part of the speaker or any profession by him to possess the same. His willingness to proffer the information or advice in the relationship which I have described is, in my opinion, sufficient ... I conclude ... in relation to the principal question arising in this case that a cause of action for breach of a duty of care in the gratuitous giving of information and advice by a person who does not profess a calling or particular capacity can be maintained ....<sup>1</sup>

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<sup>1</sup>*MLC* per Barwick CJ at 574, 577-578.

There are numerous judicial statements to the same effect. Gibbs CJ clearly did not favour the notion that it is essential that a defendant possess or profess to possess special skill or competence to be subject to a duty of care:

With all respect I find it difficult to see why in principle the duty should be limited to persons whose business or profession includes giving the sort of advice or information sought and to persons claiming to have the same skill or competence as those carrying on such a business or profession ...<sup>2</sup>

Brennan J noted that authority of the Court indicates that possession or profession to possess special skill or competence is not essential to a duty of care:

In [*Hedley Byrne v Heller* and *Candler v Crane, Christmas & Co.*] the defendant was a person having special skill or experience in the field in which the advice or information was given, but it is now established that it is not essential that a defendant who is under a duty of care should possess or hold himself out as possessing special skill or experience: see *MLC v Evatt*; *Shaddock*.<sup>3</sup>

Mason J found the notion that a defendant must have special skill and competence to be subject to a duty of care to be one involving ‘no logic’:

[T]here is no logic in excluding from the class of persons liable for negligent mis-statement persons, who, though they may not exercise skill and competence, assume a responsibility to give advice or information to others on serious matters which may occasion loss or damage.<sup>4</sup>

Mason J also made the following comment in relation to standard of care:

When a person takes it upon himself to perform a task in circumstances where a reasonable man would think it necessary to call an expert the standard of care ... the law will require of him may well be that of an expert.<sup>5</sup>

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<sup>2</sup> *Shaddock* per Gibbs CJ at 234.

<sup>3</sup> *San Sebastian* per Brennan J at 371.

<sup>4</sup> *Shaddock* at 251.

<sup>5</sup> *Papatonakis v Australian Telecommunications Commission* (1985) 156 CLR 7 per Mason J at 21.

If Mason J was prepared to contemplate the possibility that a person who is not an 'expert' may be subject to the same standard of care as an expert, then *a fortiori* a person's non-expert status will not preclude a duty of care. To the same effect is a comment by Deane J:

If [a person] meddles himself, he cannot complain if the standards of care and foreseeability of injury which the law exacts of him are not those of the hypothetical person on a hypothetical Bondi tram or Clapham omnibus but those of the ordinary skilled person exercising and professing to have that special skill.<sup>6</sup>

There is therefore no shortage of statements by members of the Court supporting the proposition that it is not essential that a cleric who provides pastoral counselling for depression be a professional counsellor, or make a representation to be a professional counsellor, in order to be under a duty of care.

Similar views have been expressed in England. In *MLC* Lord Reid and Lord Morris were in the minority of the Privy Council on appeal from the Court,<sup>7</sup> however their approach was consistent with that taken by Barwick CJ in *MLC*.<sup>8</sup>

Their Lordships rejected the notion that a defendant must possess special skill, or hold themselves out as possessing special skill in order to be subject to a duty of care for provision of advice for information:

We can see no ground for the distinction that a specially skilled man must exercise care but a less skilled man need not to do. We are unable to accept the argument that a duty to take care is the same as a duty to conform to a particular standard of skill .... it was argued that an adviser ought not to be under any liability to exercise care unless he had, before the advice was sought, in some way held himself out as able and willing to give advice. We can see no virtue in a previous holding out.<sup>9</sup>

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<sup>6</sup> *Ibid* per Deane J at 36.

<sup>7</sup> *MLC v Evatt* (1970) 122 CLR 628.

<sup>8</sup> *Ibid* per Lords Reid and Morris at 648: 'We think the judgments of the majority in the High Court are consistent with the views we have expressed'.

<sup>9</sup> *Ibid* 646.

Lord Devlin similarly remarked:

If a defendant says to a plaintiff: “Let me do this for you: do not waste your money in employing a professional, I will do it for nothing and you can rely on me.” I do not think he could escape liability merely because he belonged to no profession or calling ....<sup>10</sup>

In *Nally* the defendants made a representation of competence to treat depression.<sup>11</sup> Such a representation favours the existence of a duty of care, but is not essential, just as a representation to be a professional counsellor is not essential.

In the two sections which follow, circumstances relevant to whether a cleric knew or ought to have known that a client was likely to rely on pastoral counselling for depression, and whether such reliance would be reasonable, are considered.

## **8.2 Knowledge of the likelihood of reliance**

Whether a cleric knew or ought to have known a client was likely to rely on pastoral counselling for depression will depend on the circumstances. That said, it seems unlikely that a cleric would not or should not know that a client is likely to rely on pastoral counselling for depression.

A cleric would probably not provide pastoral counselling for depression if the cleric thought it would not be taken seriously, and a client would probably not seek a solution for depression from a cleric if he or she did not think the cleric could provide one.

The mere fact that a client attends counselling is arguably suggestive of the likelihood of reliance. Moreover, some clients may seek help from a cleric because they desire a religious solution to their depression. They may therefore be likely to rely on pastoral counselling for depression. It could be argued that clergy should know this.

There appears to be some basis in reality for the proposition that some people will rely on clergy to assist them regarding their depression, even if a non-professional counsellor:

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<sup>10</sup> *Hedley Byrne & Co. Ltd v Heller & Partners Ltd* [1964] AC 465 at 531.

<sup>11</sup> See section 1.1.

The Spirit leads clergy ... into the service of God's reign of love, to witness and to minister the healing ... God desires ... Because of this many people from within the Church, and even beyond it, are drawn to them in the hope that their grief and anguish might find healing. They come to the Church's ... ministers in trust and vulnerability ...<sup>12</sup>

Again, it could be argued that clergy should know this. The Wood Royal Commission states:

Clergy are in a position of trust and authority within the pastoral environment, which is characterised by inequality of power. As such there is a need to recognise that ... because the minister has the greater power and pastoral responsibility, it is his duty to guard the boundary against sexual contact.<sup>13</sup>

Clergy could be expected to be aware of the general trust that is often reposed in them. Whether this means they should know that a client is likely to trust them regarding pastoral counselling for depression is a different matter. It is arguably a relevant consideration in that inquiry.

### **8.3 Reasonableness of reliance**

Barwick CJ indicated the following matters determine the reasonableness of reliance:

The nature of the subject matter, the occasion of the interchange, and the identity and relative position of the parties as regards knowledge actual or potential and relevant capacity to form or exercise judgment will all be included in the factors which will determine the reasonableness of the acceptance of, and of the reliance by the recipient upon, the words of the speaker.<sup>14</sup>

Applying this to pastoral counselling for depression, the 'nature of the subject matter' is serious, making reliance more likely to be reasonable. Similarly, 'the occasion of the interchange' is serious.

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<sup>12</sup> *Integrity in Ministry*, 9-10.

<sup>13</sup> Wood, The Hon Justice J.R.T. 1997 *Royal Commission into the New South Wales Police Service, Volume V: The Paedophilia Inquiry*, Chapter 11 - The Churches, Royal Commission into the New South Wales Police Service 1997, Sydney, 1001.

<sup>14</sup> *MLC* at 571.

Almost by definition, a client is unable to solve the problem of depression by themselves, otherwise he or she would not have sought help.

The capacity of a client ‘to form or exercise judgment’ may be restricted by intellectual limitations or a lack of knowledge about depression and its treatments. Such capacity may also be reduced by disabling symptoms of depression.

As already seen, depressed people may be unable to make balanced judgments regarding treatment, or be withdrawn and isolated with compromised desire or ability to seek appropriate care or even have a tendency towards harming themselves.<sup>15</sup>

That a recipient of advice or information, and by analogy a recipient of counselling, believes ‘that the speaker has superior information, either in hand or at hand with respect to the subject matter or that the speaker has greater capacity or opportunity for judgment than the recipient’,<sup>16</sup> will create ‘the element of trust’.<sup>17</sup>

It is not essential, however, that the client believe the cleric to have a ‘greater capacity or opportunity for judgement’ regarding depression than the client in order for a duty of care to exist:

But I do not think that ... inequality in these respects must necessarily in fact be present or be thought to be present if the special relationship is to exist.<sup>18</sup>

Most Christian clergy, in theory, possess divinely ordained authority. Many have authoritative titles such as Reverend Doctor, Senior Pastor, or Father. This could be relevant to assessing the reasonableness of a client’s reliance. It has also been said:

The office [clergy] bear, the Master they serve, the interests committed to them, and the influence and power they exert, throw upon them a burden of responsibility which is borne by no other class of men.<sup>19</sup>

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<sup>15</sup> See section 3.6.

<sup>16</sup> *MLC* at 571.

<sup>17</sup> *Id.*

<sup>18</sup> *MLC* at 571.

<sup>19</sup> Spring, G. 1986 *The Power of the Pulpit: Thoughts addressed to Christian Ministers*, Banner of Truth Trust Edinburgh, 167.

If a cleric intends to induce a client to act in a particular way regarding the management of his or her depression, this will favour a conclusion that reliance was reasonable:

An intention to induce a person to whom information or advice is given to act in a particular way is ... one of the various means by which it may be shown that the reliance ... is reasonable.<sup>20</sup>

Where a cleric intends a client to act on the counselling, the reasonableness of any reliance may not be critical. A majority of the Court consisting of Gibbs CJ, Mason, Wilson and Dawson JJ stated:

In cases where the defendant intends a statement to operate as a direct inducement to action, the reasonableness of any reliance will not be a critical factor ...<sup>21</sup>

Another matter of possible relevance is that in contract law categories of relationships have been developed in which the influence of one party to a contract in persuading the other to make the contract will be presumed to be undue and liable to be set aside by a court, unless the presumption is rebutted.<sup>22</sup>

According to Dixon J, the presumption applies:

Whenever one party occupies or assumes towards another a position naturally involving an ascendancy or influence over that other, or a dependence or trust on his part.<sup>23</sup>

Clergy are within such a category. Carter and Harland stated:

Relationships between the following classes of persons have been judicially recognised as falling within this category: parent (or person in loco parentis) and child; guardian and ward; solicitor and client; trustee and beneficiary; physician and patient; and religious adviser and advisee.<sup>24</sup>

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<sup>20</sup> *Esanda* per Dawson J at 256.

<sup>21</sup> *San Sebastian* at 358.

<sup>22</sup> Carter & Harland, 505.

<sup>23</sup> *Johnson v Buttress* (1936) 56 CLARE 113 per Dixon J at 134-135.

<sup>24</sup> Carter & Harland, 512, citations omitted. Although the case which Carter & Harland cite for the inclusion of religious adviser and advisee within this category is an old English one, *Allcard v Skinner* (1887) 36 CH D 145, it may still be relevant. Fisher and MacFarlane in *Churches, Clergy and the Law* cite the same case in this context without questioning its relevance, at 179.

If a relationship involving pastoral counselling for depression is one ‘naturally involving an ascendancy or influence’ or ‘dependence or trust’, this would arguably favour a conclusion that reliance on pastoral counselling for depression is reasonable.

In the end the only way of judging whether reliance was reasonable, or whether a cleric should have known that a client was likely to rely on the counselling, is to look at all the circumstances. Therefore in the remainder of this chapter the relevance of various circumstances which may apply will be examined.

#### **8.4 The degree of directiveness of the counselling**

It is possible that pastoral counselling for depression as defined herein might not include advice to take a course of action, but merely the provision of information to the effect that a religious remedy for depression may be of assistance.

Advice and information do not require analysis by reference to different legal principles as for advice. This is suggested by the following comment of Barwick CJ in *MLC*:

I have not differentiated information and advice in the treatment I have given to the subject matter. I have considered whether each can be the subject of the duty of care, and whether there is any valid reason to distinguish in this connexion between information and advice. After reflection, I can find none which would compel or require a different conclusion in connexion with the one from that drawn in the other. In many instances the distinction between the two is very slight: on occasions “information” spills over and becomes inextricable from “advice”: but, even where the separation of the two is quite substantial, I do not think each calls for separate treatment. Incorrect information can cause loss and damage as well as incorrect advice ...<sup>25</sup>

The Court reached the same conclusion in *Shaddock*. Gibbs CJ, Stephen and Mason JJ stated respectively:

I respectfully agree with the opinion of Barwick CJ that there is no valid ground on which to distinguish between information and advice ... Although the giving of advice must necessarily require an exercise of skill or judgment, and the giving of information may not necessarily do so, a person giving information may be so placed that others can reasonably rely on his ability of carefully to ascertain and impart the information.<sup>26</sup>

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<sup>25</sup> *MLC* at 572.

<sup>26</sup> *Shaddock* per Gibbs CJ at 233.

[T]he precise boundary between [information and advice] is no doubt difficult to draw ... [in *MLC*] their Lordships drew no distinction between the two, any attempt to do so seems to be unnecessary in principle and likely to lead to insoluble problems in practice.<sup>27</sup>

I consider that this Court should now adopt Barwick CJ's statement of the conditions which give rise to a duty of care in the provision of advice or information. It will be noted that his Honour specifically equated the provision of information with the provision of advice, a conclusion which conformed to his Honour's view that liability is not confined to those who carry on a profession or business.<sup>28</sup>

The statement that information and advice do not require separate treatment requires some qualification, as Barwick CJ acknowledged:

But, no doubt, it may be more difficult to make out all the essential elements of the necessary special relationships in connexion with the giving of information than it may be in connexion with the giving of advice.<sup>29</sup>

In particular, where a cleric merely provides information to the effect that a religious remedy for depression may be of assistance, there may be no intention to induce the client to act in a particular way. As seen in the above section, where such an intention is absent, the element of reasonable reliance may be more difficult to make out:

An intention to induce a person to whom information or advice is given to act in a particular way is ... one of the various means by which it may be shown that the reliance ... is reasonable.<sup>30</sup>

The fact that a cleric does not have such an intention does not mean no duty. The presence of such an intention makes reliance more likely to be reasonable; the absence of such an intention does not mean reliance could not be reasonable.

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<sup>27</sup> *Ibid* per Stephen J at 243.

<sup>28</sup> *Ibid* per Mason J at 251 (Aickin J agreeing).

<sup>29</sup> *Id.*

<sup>30</sup> *Esanda* per Dawson J at 256.

Urging or persuasion is a stronger form of communication than advice, to the extent that this form of communication can be differentiated from advice. Where a duty of care arose for counselling which included advice to pursue a religious remedy for depression, a duty of care would *a fortiori* arise for urging or persuasion to do so.

Conversely, a suggestion to pursue a religious remedy for depression is a less directive form of communication than advice, and is therefore less likely to attract a duty of care, other circumstances being equal.

## **8.5 The cleric is a reluctant participant in the counselling**

In *Tepko* Gleeson CJ, Gummow and Hayne JJ considered the fact that ‘the Board plainly was a reluctant participant; the Board did not wish to give Mr Neal information and it resisted giving it until eventually it “caved in” in concluding that Mr Neal’s reliance was unreasonable.’<sup>31</sup>

The relevance of this consideration may translate to the pastoral counselling context, thus if a cleric is pressed by a client to provide pastoral counselling for depression and reluctantly agrees it could be argued that reliance by the client would be unreasonable.

On the other hand in *Tepko* Kirby and Callinan JJ, with whom McHugh J agreed, said ‘reluctance ... could not justify negligence, or negate a duty of care’.<sup>32</sup>

If the cleric encouraged the client to undergo pastoral counselling for depression, whether by advertisement or otherwise, this would favour a conclusion that reliance was reasonable.

A US commentator suggested that in *Nally*, ‘Nally was quite dependent on the counsellors, and their extensive use of advertising ... in the area of counselling strengthened his dependence on, and faith in them’.<sup>33</sup> Another US commentator suggested that merely by being clergy, clergy tacitly invite solicitation of their counsel,<sup>34</sup> though this is probably of limited legal significance.

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<sup>31</sup> *Tepko* at 784.

<sup>32</sup> *Ibid* 800.

<sup>33</sup> Burton, 498.

<sup>34</sup> Bergman, 64.

## **8.6 Express downplaying of competence**

It could be argued that should a cleric expressly play down their competence to deal with depression, for example by expressly referring to limitations in training or expertise, this tells against a conclusion that reliance was reasonable. The capacity of depressed clients to exercise judgment would be relevant in assessing the reasonableness of any reliance, however.

It is doubtful whether many clients with major depressive disorder or bipolar disorder could properly assess the implications of receiving counselling for depression from a non-professional counsellor.

## **8.7 The client is attending a general practitioner or mental health professional, or is able to do so**

It is possible that in addition to receiving pastoral counselling for depression, the client could be receiving assistance from a general practitioner or mental health professional, or have the option of obtaining such assistance.

In *Tepko* there was a conflict of opinion as to whether the plaintiff's access to other advice meant that the plaintiff's reliance on the defendant's information was unreasonable. According to Gleeson CJ, Gummow and Hayne JJ:

[T]he circumstances here were not such as to make it reasonable for Mr Neal to rely upon [the defendant's information] ... Mr Neal ... had access to expert advice, which he utilised.<sup>35</sup>

By way of contrast, Kirby and Callinan JJ, with whom McHugh J agreed, stated:

That the appellant might have access to other advice did not relieve the respondent of his own duty to provide a careful and rational estimate - not one inflated knowingly or carelessly.<sup>36</sup>

A client may have the option to attend to a general practitioner or mental health professional in addition to pastoral counselling for depression. This is not particularly significant.

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<sup>35</sup> *Tepko* at 784.

<sup>36</sup> *Tepko* per Kirby & Callinan JJ at 805, McHugh J agreeing.

Attendance of pastoral counselling for depression may mean that a client decides not to seek help from other practitioners, and a depressed client may be unable to make balanced or informed decisions concerning treatment options.<sup>37</sup>

Even where the client is attending a general practitioner or mental health professional, the client may rely on the pastoral counselling and therefore pay less attention to advice or information from the general practitioner or mental health professional. Hence such attendance would not obviate the need for care to be taken in the provision of pastoral counselling for depression.

### **8.8 Characteristics of the particular cleric**

Older age of the cleric may be suggestive of wisdom or reliability, and higher position of the cleric within the church may be associated by clients with greater experience. These matters may favour a conclusion that reliance was reasonable. The same could be said where the cleric exhibited a charismatic demeanour.

### **8.9 Characteristics of the cleric's church**

The characteristics of the cleric's church are arguably relevant to the reasonableness of the reliance. Provision of counselling as part of a large counselling team to large numbers of people might favour a conclusion that reliance was reasonable. Kaufman J noted in *Nally* that the defendants were 'decidedly not ... a small band of simple pastors who offered occasional counselling on minor matters to the faithful few'.<sup>38</sup>

### **8.10 Religious background of the client**

The capacity of clients 'to form or exercise judgment'<sup>39</sup> could also be affected by a high regard for the abilities of clergy instilled in them by religious or social factors. The alleged facts, if true, contained within reported judgments of some US cases regarding sexual misconduct by clergy illustrate this.

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<sup>37</sup>Section 3.10.

<sup>38</sup>253 Cal. Rptr 97 (Cal. 1988), 114.

<sup>39</sup>*MLC* per Barwick CJ at 571.

For example in *EJM v Archdiocese of Philadelphia* the plaintiff alleged:

Because of the ... exalted position in which priests were regarded within my family, I did not believe or consider that defendant Father Pinkowski's actions with me were wrong. My mindset was that - because he was a priest - he had to be right about this therapy ...<sup>40</sup>

Similarly in *Langford v Roman Catholic Diocese* it was alleged:

Monsignor Sivillo ... encouraged [the plaintiff's] dependence on him by emphasising the mystical and esoteric nature of his power to cure her. Plaintiff asserts that she ... believed that if she angered him, she would lose her lifeline to God and continued health.<sup>41</sup>

### **8.11 Reference to Biblical passages**

Material within the Bible could increase a client's reliance on pastoral counselling for depression or a religious remedy for depression recommended by the cleric if referred to by the cleric. Such material might include:

They cried to you and were saved; in you they trusted and were not disappointed.<sup>42</sup>

So we say with confidence, "The Lord is my helper" ...<sup>43</sup>

This sort of material would not signify to everyone that pastoral counselling for depression should be relied upon. The relevant question, though, is how it may be construed by a depressed client.

### **8.12 The client is disinterested in the counselling**

If a client is merely attending the pastoral counselling for depression to pass the time or to have a conversation, and does not evince any willingness to take it seriously, then this may well preclude a conclusion that the cleric should have known that reliance was likely, or that any reliance was reasonable.

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<sup>40</sup> 622 A2d 1388, 1390 (Pa. Super. 1993).

<sup>41</sup> 677 NYS2d 436, 437 (Sup. 1998).

<sup>42</sup> *Holy Bible*, Psalm 22: 5 (New International Version 1995 Hodder & Stoughton London).

<sup>43</sup> *Ibid* Hebrews 13:6.

### **8.13 The client is a mental health professional**

It is conceivable that the client of a cleric could be a mental health professional or general practitioner. In such a situation consideration of the 'identity and relative position of the parties as regards knowledge actual or potential and relevant capacity to form or exercise judgment' might suggest any reliance would be unreasonable.<sup>44</sup>

### **8.14 A particularised inquiry is necessary**

It could be argued that whether a cleric owes a duty of care for pastoral counselling for depression should not depend on differences of arguably minor detail such as the characteristics of the cleric, the size of the cleric's church, the religious background of the client, whether or not the cleric refers to the Bible, or the degree of enthusiasm which the cleric or the client shows for the counselling,

While it may be that some of these circumstances are not of major importance, the circumstances of the particular case must be examined,<sup>45</sup> as opposed to drawing a sweeping conclusion that the elements of knowledge and reasonableness of reliance would always be present, or never be present.

## **Conclusion**

Whether a cleric knew or should have known of a likelihood that a client would rely on pastoral counselling for depression will depend on the circumstances. That said, it seems improbable that a cleric would not or should not know of the likelihood of reliance. A cleric would probably not provide pastoral counselling for depression if they thought it would not be taken seriously.

As to whether such reliance, if it occurred, would be reasonable, this will also depend on the circumstances, as the discussion in this chapter demonstrates. Where a cleric intended the client to act on the counselling, this would also favour a conclusion that reliance on the counselling was reasonable.<sup>46</sup>

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<sup>44</sup> *MLC* at 571.

<sup>45</sup> Section 6.3.

<sup>46</sup> *Esanda* per Dawson J at 256: 'An intention to induce a person to whom information or advice is given to act in a particular way is ... one of the various means by which it may be shown that the reliance ... is reasonable.'

There are a number of additional circumstances which, where they applied in a particular case, would favour a conclusion that reliance on the counselling, if reliance occurred, would be reasonable. These include the facts that where clergy provide pastoral counselling for depression the nature of the subject matter and the occasion of the interchange are serious. The capacity of a client to form or exercise judgment concerning management of depression may be restricted by disabling symptoms of depression, lack of knowledge about depression and its treatments, or by intellectual limitations. Most Christian clergy in theory, possess divinely ordained authority, and many clergy have authoritative titles such as Reverend Doctor, Senior Pastor, or Father.

A number of circumstances which, if applicable in a particular case, would tell against a conclusion that any reliance would be reasonable. These include a cleric's reluctant participation in the counselling, an express downplaying of competence by the cleric, and perhaps circumstances where the knowledge of the client in relation to depression and treatments for depression is known by the parties to be greater than that of the cleric.

The facts that the cleric is a non-professional counsellor or does not make an express representation to be a professional or competent counsellor will not in themselves preclude a duty of care, and will not in themselves preclude a conclusion that reliance is reasonable or that a cleric knew or should have known of a likelihood of reliance, but are relevant to consideration of those questions.

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The Supreme Court of Canada has stated:

The idea that the person who introduces a risk incurs a duty to those who may be injured lies at the heart of tort law.<sup>47</sup>

In the next chapter the possible relevance in Australia of whether pastoral counselling for depression could increase the risk to, or vulnerability of, a client will be considered.

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<sup>47</sup> *Bazley v Curry* [1999] 2 SCR 534 per McLachlin J at 545 delivering the judgment of the Court.

## Chapter 9

# VULNERABILITY

### Introduction

The elements of knowledge and reasonableness of reliance to which Barwick CJ referred in *MLC* were said by his Honour to be ‘essential’ elements.<sup>1</sup> That is not to say that a duty of care will arise regarding the provision of advice or information, or the provision of a service, if those elements are present.

Rather, it may suggest that such a duty of care will not generally arise unless they are. Previous cases are not of direct assistance in determining whether any further elements, apart from reasonable foreseeability of harm to the plaintiff from the defendant’s conduct, would be needed or would suffice in combination with those elements to establish a duty of care where clergy provide pastoral counselling for depression.

As will be seen in this chapter, there has been an assortment of comments made by members of the Court pertaining to notions of vulnerability or risk. The comments suggest that the vulnerability of the plaintiff to the defendant’s conduct, or which may be viewed as essentially the same thing, the creation or increase of a risk of injury to the plaintiff by the defendant, is an important element favouring a duty of care.

This chapter demonstrates that vulnerability has been important in a pure economic loss case, namely *Perre*, and in a case involving the duty of care of a public authority to take measures to protect the plaintiff from physical injury, namely *Crimmins*. (Principles in the *CLA* for determining whether a public authority owes a duty of care are not relevant to clergy or churches.)<sup>2</sup>

It is then argued that the plaintiff’s vulnerability to the conduct of the defendant is of likely relevance to a case involving pastoral counselling for depression.

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<sup>1</sup> *MLC* at 570.

<sup>2</sup> Sections 40-46 of the *CLA* contain such principles.

## 9.1 *Perre and others v Apand Pty Ltd*

The plaintiffs included members of the Perre family, Perre Vineyards Pty Ltd, Warruga Farms Pty Ltd, and Rangara Pty Ltd. They were engaged in the business of growing or packing potatoes in South Australia, mostly for export to West Australia where it was most profitable to sell them.

These activities were conducted within 20 km of a property owned by the Sparnons. West Australian regulations prohibited the importation into that state of potatoes grown on land within 20 km of land infected with bacterial wilt. The defendant, Apand, supplied seed potatoes infected with bacterial wilt to the Sparnons. The plaintiffs alleged this was a breach of a duty of care which caused them economic loss.

All members of the Court held that the defendant owed a duty of care to Warruga Farms, which was the only entity to both grow potatoes and export them to West Australia. A majority of the Court held that a duty had been owed to the owners of Rangara and members of the Perre family,<sup>3</sup> and to Perre Vineyards.<sup>4</sup>

The vulnerability of the plaintiffs to the defendant's conduct was among the matters to which Gleeson CJ, McHugh, Gummow, Kirby and Callinan JJ adverted in holding that a duty of care existed.

After noting that 'the obvious vulnerability of a specific plaintiff was influential' in *Caltex Oil Australia v The Dredge "Willemstad"*,<sup>5</sup> Gleeson CJ emphasised the defendant's knowledge of the plaintiffs' vulnerability to the impact of the introduction of the diseased seed:

I would emphasise the following matters. The acknowledgment in the internal communications of the [defendant] that there was a need to be careful so as not to damage the interests of those involved in potato growing on land within 20 km of a farm that might be affected by bacterial wilt, is not merely a matter of legally irrelevant prejudice. It shows actual foresight of the likelihood of harm, and knowledge of an ascertainable class of vulnerable persons.<sup>6</sup>

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<sup>3</sup> Hayne J dissented that a duty had been owed to Rangara and the Perres.

<sup>4</sup> McHugh and Hayne JJ dissented that a duty had been owed to Perre Vineyards. The partial dissents of McHugh and Hayne JJ were based on the fact that the loss was wholly economic and the plaintiffs whom they excluded from the duty of care were not within an ascertainable class of persons affected by the defendant's conduct - see 234-235 and 308 respectively.

<sup>5</sup> (1976) 136 CLR 529. In *Caltex* the plaintiff was vulnerable to the fact that the defendant had damaged an oil pipeline upon which it relied to supply its terminal with products.

<sup>6</sup> *Perre* per Gleeson CJ at 195.

McHugh J's judgment contained extensive discussion of the relevance of vulnerability to cases involving economic loss and to the law of negligence generally. Further reference will be made to those comments below.<sup>7</sup> For now, it is noted that McHugh J viewed the following questions as relevant:

Upon the facts of this case, whether or not Apand owed a duty of care depends on the answers to the following questions: 1. Was the loss suffered by the Perres ... reasonably foreseeable? 2. If yes to question 1, would the imposition of a duty of care impose indeterminate liability on Apand? 3. If no to question 2, would the imposition of a duty of care impose an unreasonable burden on the autonomy of Apand? 4. If no to question 3, were the Perres or some of them vulnerable to loss from the conduct of Apand? 5. Did Apand know that its conduct could cause harm to individuals such as the Perres? I do not think any other factors are relevant ...<sup>8</sup>

In common with McHugh J and other members of the Court, Kirby J was concerned to establish that indeterminate liability, or in other words liability to an unascertainable class of persons, would not be imposed on the defendant. Kirby J also saw the plaintiffs' vulnerability to the defendant's conduct as important:

There was no risk of indeterminacy in this case. The ambit of the reasonably foreseeable, indeed known, vulnerability was measured by precise considerations of geographical proximity ... .. Potato farmers within that radius [of 20km] were in a relationship of ... neighbourhood because of their vulnerability arising from an almost contiguous physical propinquity to a farm which Apand decided to introduce the uncertified seed [potatoes] ...<sup>9</sup>

Callinan J spoke of the risk to the defendant's conduct posed to the plaintiffs, or in other words the vulnerability of the plaintiffs to that conduct:

What [the defendant] did went considerably beyond careless inadvertence and resulted from conscious decisions carrying with them obvious risks ... several ... factors ... are important in this case, such as the experimental nature of the respondent's activity, the commanding position of [the defendant] in the industry, the risks associated with the use of a new ... uncertified seed ... the relative ease of avoiding the risk, and the great harm done to the appellants ...<sup>10</sup>

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<sup>7</sup> See sections 9.2 and 9.3.

<sup>8</sup> *Ibid* 231.

<sup>9</sup> *Ibid* 289.

<sup>10</sup> *Ibid* 329, 331.

Gummow J also referred to the risk the defendant's conduct posed to the plaintiffs:

Apand was aware ... of the threat that bacterial wilt posed to [the plaintiffs] ... [and] was in control of the initiation and conduct of the experimental activities using the Sparnon's property ... The Perres had no way of appreciating the existence of the risk to which they were exposed by the conduct of the Apand experiment and no way to protect themselves against that risk ... Here, the relevant risk ... was in the exclusive control of Apand ... <sup>11</sup>

Gaudron J took an approach which was, at least superficially, different to that taken by other members of the Court, focussing on the 'control' of the situation by the defendant and 'dependence' of the plaintiff:

Where a person is in a position to control the exercise or enjoyment by another of a legal right, that position of control and, by corollary, the other's dependence on the person with control are, in my view, special factors, or, which is the same thing, give rise to a special relationship of "proximity" or "neighbourhood" such that the law will impose liability on the person with control if his or negligent act or omission results in the loss or impairment of that right and is, thereby, productive of economic loss.<sup>12</sup>

However the following comment by McHugh J in *Perre*, referring to the approach taken by Gaudron J in an earlier case, suggests that the difference between the approach of Gaudron J in *Perre* and that of other members of the Court may have been more one of terminology than of substance:

[I]n *Hill v Van Erp*, a case of negligent performance of a service ... neither reliance nor assumption of responsibility to the plaintiff was present. Gaudron J dismissed these criteria as indicators of duty and relied on the concept of control to found a duty. But that is simply another way of saying the plaintiff is vulnerable to the defendant's conduct because the defendant controls the situation.<sup>13</sup>

*Crimmins* closely followed *Perre* in time, and the vulnerability of the plaintiff to the defendant's conduct again received close attention, as will be seen in the next section.

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<sup>11</sup> *Ibid* per Gummow J at 259.

<sup>12</sup> *Ibid* per Gaudron J at 201. Gaudron J's reference to impairment of a 'legal right' is not of relevance to the thesis. While it could be said that clients have a moral right not to be treated negligently, it is difficult to identify a legal right which negligent counselling would impair. Counselling which leads to damage may create a legal right to compensation, but that is not a right impaired by the counselling.

<sup>13</sup> *Ibid* per McHugh J at 229.

## 9.2 *Crimmins v Stevedoring Industry Finance Committee*

*Crimmins* concerned whether a public authority which allocated stevedores to work on a particular wharf, where they would be employed by stevedoring companies, owed a duty of care to those workers involving requirements to warn them of the dangers of asbestos and encourage the employers to adopt safe working practices. By a five-two majority the Court held that a duty of care existed.

Gleeson CJ agreed with McHugh J's reasons.<sup>14</sup> McHugh J stated, under a heading 'The plaintiff was vulnerable as the result of the directions of the Authority':

It can seldom be the case that a person, who controls or directs another person, does not owe that person a duty to take reasonable care to avoid risks of harm from that direction or the effect of that control ... What is required to discharge a duty arising from a direction or control of a person's freedom of action will depend on the circumstances, and, in some cases, it may be very little. But usually the very fact of the direction or control will itself be sufficient to found a duty. Where the person giving the direction ... knows that there is a real risk of harm unless the direction is given or the control is exercised with care, the case for imposing a duty is overwhelming.<sup>15</sup>

McHugh J's reference to 'direction' was not limited to situations where an obligation on the part of the person being directed to follow the direction existed.<sup>16</sup>

Kirby J viewed the vulnerability of the plaintiff to the directions of the defendant as a 'powerful' factor favouring a duty of care:

As against these [factors telling against a duty of care] others more powerful ... argue in favour of accepting that a duty of care existed in this case. The most important of the considerations include: The particular vulnerability of persons in the position of the deceased and the lack of any real opportunity to protect themselves when allocated by the Authority to work in conditions involving an unsafe or unhealthy working situation ...<sup>17</sup>

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<sup>14</sup> *Crimmins* per Gleeson CJ at 13.

<sup>15</sup> *Ibid* per McHugh J at 42-43.

<sup>16</sup> McHugh J gave examples of cases where direction or control point towards the existence of a duty of care, including 'the police officer who directs traffic, the gaoler who has the custody of the prisoner, and the helpful bystander, who obligingly points the way to the traveller seeking guidance' - at 42-43. It is clearly not compulsory to follow the directions of helpful bystanders.

<sup>17</sup> *Ibid* per Kirby J at 85.

The increased vulnerability of the plaintiff by reason of the defendant's conduct also played a prominent role in the judgment of Gaudron J. Her Honour concluded that the plaintiff's vulnerability to injury 'was magnified by the Authority's directions':

In the present case Mr Crimmins was not only vulnerable to injury by reason of the hazardous nature of his employment but he was less able than employees in most other industries to protect his own interests ... And his relative powerlessness in this regard was magnified by the Authority's directions as to when and where he was to work ... Given the vulnerability of the late Mr Crimmins, the knowledge the Authority had or should have had, and its position to control or minimise the risks associated with the handling of asbestos, there was, in my view, a relationship between Mr Crimmins and the authority giving rise to a duty of care ...<sup>18</sup>

Callinan, Gummow and Hayne JJ in separate judgments used the language of 'control' rather than vulnerability. Callinan J held that a duty of care existed and stated:

The Act [the Stevedoring Industry Act Cth] contemplated a role for the [defendant] ... with a real capacity, and some obligations, to influence the working conditions of waterside workers ... the evidence in this case shows that ... the [defendant] exercised a large measure of control over waterside workers ... The right to exercise control and actual control are important matters in determining whether duty of care is owed.<sup>19</sup>

Gummow and Hayne JJ dissented, holding that no duty of care had been owed. Gummow J agreed 'generally with the reasons for judgment of Hayne J'.<sup>20</sup> Hayne J's view that the defendant lacked control over the safety of the plaintiff was a matter to which his Honour adverted in holding that a duty of care did not exist:

Both the power to direct and the power to control are important ... Unlike an employer, the Authority's power to influence (let alone control) the system of work used by a waterside worker or the state of the workplace to which it sent a waterside worker was limited. The Authority was not in the same position as the stevedore (which was the employer of waterside workers) to control the way in which work was done or the places and conditions in which it was to be done.<sup>21</sup>

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<sup>18</sup> *Ibid* 24-25.

<sup>19</sup> *Ibid* 114-116.

<sup>20</sup> *Ibid* 56.

<sup>21</sup> *Ibid* 98.

As seen in section 9.1, reference to control 'is simply another way of saying that the plaintiff is vulnerable to the defendant's conduct because the defendant controls the situation'.<sup>22</sup>

In the context of pastoral counselling for depression, vulnerability does not result from control. The cleric may be able to influence the client, but does not have control over the client. Rather, the client may become more vulnerable as a result of reliance on the counselling, where reliance occurs.<sup>23</sup>

'Control' is not an important factor in the context of pastoral counselling for depression. If an absence of control was a matter which precluded the cleric from being subject to a duty of care then by the same reasoning a medical practitioner would not have a duty of care because such a practitioner does not control the patient, which is not correct.

### **9.3 The relevance of vulnerability generally**

In *Perre* Gleeson CJ appeared to recognise the general relevance of vulnerability:

[K]nowledge (actual, or that which a reasonable person would have) of an individual, or an ascertainable class of persons, who is or are reliant, and therefore vulnerable, is a significant factor in establishing a duty of care.<sup>24</sup>

Gleeson CJ, Gummow, Hayne and Heydon JJ have recently confirmed the relevance of vulnerability to economic loss cases not involving provision of information or advice:

Since *Caltex Oil*, and most notably in *Perre* ... the vulnerability of the plaintiff has emerged as an important requirement in cases where a duty of care to avoid economic loss has been held to have been owed.<sup>25</sup>

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<sup>22</sup> *Perre* per McHugh J at 229.

<sup>23</sup> See the next chapter.

<sup>24</sup> *Perre* per Gleeson CJ at 194.

<sup>25</sup> *Woolcock Street Investments Pty Ltd v CDG Pty Ltd* (2003) 216 CLR 515 at 530.

Similarly, in relation to pure economic loss cases generally, McHugh J stated:

The vulnerability of the plaintiff to harm from the defendant's conduct is ... ordinarily a prerequisite to imposing a duty.<sup>26</sup>

Gleeson CJ, Gummow, Hayne and Heydon JJ have expressed a more qualified view regarding cases involving negligent information or advice, or 'misstatements':

And it may be ... that [the 'negligent misstatement' cases like *Mutual Life Citizens* ... and *Shaddock*] ... too, can be explained by reference to notions of vulnerability ... It is not necessary in this case, however, to attempt to identify or articulate the breadth of any general proposition about the importance of vulnerability ...<sup>27</sup>

On the other hand McHugh J indicated that 'vulnerability' is relevant to provision of advice or information:

The case law indicates that vulnerability as a test of duty is not restricted to the category of negligent misstatements.<sup>28</sup>

There is no convincing reason why increased economic vulnerability as a consequence of the defendant's conduct should be relevant in an economic loss case but the increased vulnerability, if any, of a client as a consequence of pastoral counselling for depression should not be relevant.

Another of the 'negligent misstatement' cases is *Tepko*, which was discussed in chapter seven. While the judgments in that case focussed mainly on the elements of knowledge and reasonableness of reliance, the vulnerability of the plaintiff was also mentioned.

The joint judgment of Gleeson CJ, Gummow and Hayne JJ referred to the fact that the property developer who brought the action in that case was 'not a vulnerable party' in the sense of being unable to obtain protection against the harm alleged.<sup>29</sup>

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<sup>26</sup> *Perre* at 225.

<sup>27</sup> *Woolcock* at 531.

<sup>28</sup> *Perre* at 225.

<sup>29</sup> *Tepko* at 784.

The judgment of Kirby and Callinan JJ, with which McHugh J agreed, also referred to the defendant's knowledge of the vulnerability of property developers, or at least of their 'anxieties and difficulties':

[The defendant] would inevitably be aware of the day to day anxieties and difficulties of developers, examples of which are the necessity to deal with and obtain approvals from other statutory and planning authorities; the opportunity cost of delays; and the likely need for assessments of a project, not only to be able to decide whether to undertake it, but also to inform financiers of the current financial situation in respect of it.<sup>30</sup>

McHugh J in particular has emphasised the significance of the plaintiff's vulnerability or invulnerability as a factor relevant to whether a duty of care exists. Speaking generally about negligence, his Honour said in *Perre*:

[T]he common law in its desire to give effect to the autonomy of each individual does not generally require a person to act as if he or she were "my brother's keeper". That is particularly so when the defendant would have to take affirmative action to save a person from suffering harm. What is likely to be decisive, and always of relevance, in determining whether a duty of care is owed is the answer to the question, "How vulnerable was the plaintiff to incurring loss by reason of the defendant's conduct?"<sup>31</sup>

McHugh J also stated in that case:

Reliance may ... be seen - for the purposes of duty of care - as an indicator of vulnerability: the plaintiff is specially vulnerable to the words and / or conduct of the defendant because he or she reasonably relied on the defendant. Reliance may also, of course, be relevant to causation. In terms of a duty of care, however, it is not reliance that is relevant but its consequence, vulnerability ... in certain circumstances "reasonable reliance" will be the appropriate test for determining whether the plaintiff was vulnerably exposed to harm from the defendant's acts or omissions.<sup>32</sup>

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<sup>30</sup> *Tepko* at 805.

<sup>31</sup> *Perre* per McHugh J at 220.

<sup>32</sup> *Ibid* 228.

Saying that the plaintiff is vulnerable to the defendant's conduct is just another way of saying that the defendant has created or increased a risk to the plaintiff. Thus McHugh J stated, consistently with his comments on vulnerability:

Ordinarily, the common law does not impose a duty of care on a person to protect another from the risk of harm unless that person has created the risk.<sup>33</sup>

Similarly, speaking generally about duty of care, Brennan J focussed on the creation or increase of a foreseeable risk of injury by the defendant:

Some broader foundation than mere foreseeability must appear before a common law duty to act arises. There must ... be either the undertaking of some task which leads another to rely on it being performed, or the ownership, occupation or use of land or chattels to found the duty ... Thus a duty to act to prevent foreseeable injury to another may arise when a transaction - which may be no more than a single act - has been undertaken by the alleged wrongdoer and that transaction - or act - has created or increased the risk of that injury occurring. Such a case falls literally within Lord Atkin's principle in *Donoghue v Stevenson*. Where a person, whether a public authority or not ... does something which creates or increases the risk of injury to another, he brings himself into such a relationship with the other that he is bound to do what is reasonable to prevent the occurrence of that injury unless statute excludes the duty.<sup>34</sup>

Lord Atkin's principle in *Donoghue* was quoted in section 6.1. It is notable that Brennan J viewed the creation or increase of a foreseeable risk of injury as important whether the defendant is a public authority or not.

## Conclusion

Previous cases are not of direct assistance in determining whether any further elements would be needed or would suffice in combination with knowledge and reasonableness of reliance to establish the existence of a duty of care where clergy provide pastoral counselling for depression.

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<sup>33</sup> *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540 at 575-576.

<sup>34</sup> *Sutherland Shire Council* at 478-479.

There have been an assortment of comments made by members of the Court pertaining to the vulnerability of the plaintiff to the defendant's conduct, or which may be viewed as essentially the same thing, the creation or increase of a risk of injury to the plaintiff by the defendant.

Vulnerability has been particularly important in cases involving pure economic loss. There is no convincing reason why increased economic vulnerability as a consequence of the defendant's conduct should be relevant in an economic loss case but the increased vulnerability, if any, of a client as a consequence of pastoral counselling for depression should not be relevant.

The Court has not definitively or comprehensively indicated the importance of vulnerability to the existence or otherwise of a duty of care, or the nature and degree of vulnerability which might be relevant to the existence of a duty of care.

Guidance from the Court which is available would appear to permit a conclusion that where a person's conduct has the potential to increase the vulnerability of another this will significantly favour the imposition of a duty of care.

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The vulnerability of a plaintiff to the conduct of a defendant may arise from the control of the plaintiff's freedom of action by the defendant. A cleric would lack control over a client, but control is not the only circumstance in which the conduct of a defendant can render a plaintiff more vulnerable.

Rather, vulnerability of a plaintiff to a defendant's conduct may result from reliance by the plaintiff on the defendant or provision of advice or information, or of a service by the defendant. Therefore whether reliance on pastoral counselling for depression could increase the vulnerability of a client will be considered in the next chapter.

## Chapter 10

### VULNERABILITY CONSEQUENT ON RELIANCE

#### Introduction

This chapter argues that pastoral counselling for depression has the potential to increase a client's vulnerability if reasonable care is not taken.<sup>1</sup>

Reliance is 'an indicator of vulnerability'.<sup>2</sup> As a general proposition, 'vulnerability can arise from circumstances other than reliance'.<sup>3</sup> There would not appear to be any way in which pastoral counselling for depression could make a client more vulnerable unless relied upon. For counselling to have any real effect, either positive or negative, the client would have to take it seriously and in that sense rely on it.

It has been said that reliance on a 'therapist' can make a client 'extremely vulnerable':

[T]he implicit trust, faith and hope that clients consciously or unconsciously give their therapist ... places the client in an extremely vulnerable position.<sup>4</sup>

If this is correct, it might follow that a client's reliance on a cleric could increase the client's vulnerability, perhaps all the more so where the cleric is a non-professional counsellor.

In fact there is little doubt that pastoral counselling for depression has the potential to increase a client's vulnerability if reasonable care is not exercised. In commenting on *Nally*, a US commentator noted:

[T]he member of the clergy could be creating a greater danger and risk to the counslee by failure to make a necessary referral.<sup>5</sup>

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<sup>1</sup>What might constitute reasonable care is discussed in chapters fourteen and fifteen.

<sup>2</sup>*Perre* per McHugh J at 228.

<sup>3</sup>*Ibid* per Gleeson CJ at 194.

<sup>4</sup>Robertson, J.D. 1988 *Psychiatric Malpractice: Liability of Mental Health Professionals* John Wiley & Sons New York, 429.

<sup>5</sup>Burek, 159. Whether mental harm from unnecessarily prolonged depression might be compensable injury in itself is considered in Appendix A.

Another US commentator writing about *Nally* seemed to connect a client's reliance to vulnerability on the part of the client:

There is a certain amount of vulnerability involved in any type of power relationship. The counselee looks to the cleric for guidance, and is placing his or her faith and trust in the cleric to fulfill that need. To a certain extent, it is the feeling of powerlessness that leads the counselee into the relationship.<sup>6</sup>

The proposition that reliance on pastoral counselling for depression by a client could increase the client's vulnerability requires exposition. There are two main ways in which this could be so.

First, such reliance could divert or delay a client from using the main treatments for depression and may thus lead to unnecessarily prolonged depression.

Second, some forms of pastoral counselling for depression could exacerbate a client's depression if relied on or taken seriously by the client. These matters will be considered in this chapter.

### **10.1 Diversion or delay from use of the main treatments**

The main treatments for depression are anti-depressant medication or cognitive behavioural therapy in the case of major depressive disorder, or other pharmacological treatments in the case of bipolar disorder.<sup>7</sup>

On the evidence of the *NHRMC Guidelines* and the *APA Guideline*,<sup>8</sup> it appears that the main treatments for depression are generally more useful for major depressive disorder and bipolar disorder than pastoral counselling for depression.<sup>9</sup>

A client could rely on pastoral counselling for depression in deciding how to manage their depression and thereby be diverted or delayed from using the main treatments for depression.

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<sup>6</sup>Burton, 513.

<sup>7</sup>See section 3.7.

<sup>8</sup>See section 3.7.

<sup>9</sup>See section 3.8.

The client could thereby experience unnecessarily prolonged depression and thus be more vulnerable to loss or injury from the depression should the pastoral counselling be ineffective. For example, as occurred in *Nally*, a cleric might advise a client to request help from God and to study a religious text in order to recover from depression:

When Rea [one of the defendants] stepped out of the witness box ... several things were clear. Rea had never told Ken to seek any other source of help other than God ... Rea conceded that ... he had continued to admonish Ken that his emotional problems could be solved by accepting God's teachings.<sup>10</sup>

[T]he *Nally* complaint alleged that the counselors at the church told Nally to read the Bible, pray, listen to taped sermons ...<sup>11</sup>

We [the defendants] urged him [Nally] to let the Word of God lead him to intimate knowledge and appropriation of the resources available in the One who wanted to heal his troubled mind.<sup>12</sup>

A client could rely on such advice, either in the short-term during the pastoral counselling relationship, or on an ongoing basis after the conclusion of the counselling. The diversion or delay may occur because the client's attention is focussed on the religious remedy, or because the client is influenced to use the religious remedy.

Diversion or delay could occur whether the client is actively pursuing measures recommended by the cleric, or simply attends several sessions of the pastoral counselling for depression seeking a solution for depression in circumstances where he or she might otherwise have attended a mental health professional or general practitioner.

Such diversion or delay may also occur because the client attends the pastoral counselling for depression or pursues a religious remedy put forward by the cleric and obtains no improvement, and this adds to the client's pessimism concerning the effectiveness of treatments and makes the client less likely to try another treatment: 'features of major depressive disorder may include poor motivation [and] pessimism over the effectiveness of treatments'.<sup>13</sup>

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<sup>10</sup>Weitz, 113-115.

<sup>11</sup>Ericsson, 172.

<sup>12</sup>MacArthur J.F. (one of the defendants in *Nally*) 1994 *Introduction to Biblical Counseling* Word Publishing Dallas, 5.

<sup>13</sup>APA *Guideline*, 8.

Alternatively, a client who is already using one of the main treatments for depression, or attending a mental health professional or general practitioner, could cease such measures in reliance on the pastoral counselling for depression. This may not be a balanced decision on the part of the client, however ‘those in psychological distress are often the least able to make balanced judgments’.<sup>14</sup>

While experiencing unnecessarily prolonged depression the client may suffer loss or injury from the depression, for example from a suicide attempt, which might not have occurred had the client used the main treatments for depression, or used them earlier.

Not all pastoral counselling for depression could sensibly be described as faith healing, though there is some resemblance between the two situations. The following comment regarding faith healing illustrates, if any further illustration is needed, the way in which pastoral counselling for depression could increase a client’s vulnerability:

Healing is effected in many ways, but I have yet to see a full-time professional faith healer who is capable of routinely helping a person to the degree possible with traditional medicine and / or psychotherapy when used alongside prayer. In some instances, delaying the use of doctors to whom God has imparted healing wisdom can mean needless suffering or early death. Ultimately, it is foolish not to combine the best physical, psychological and spiritual care available ...<sup>15</sup>

Weitz provides an example of the potential for serious adverse consequences if medical treatment is delayed or not obtained due to reliance on a cleric’s advice:

Paul Michener of Waynesville, Ohio, spoke from personal experience and offered a contrary opinion [to the suggestion that clergy should never be subject to a duty of care for their words]. “Why shouldn’t clergymen be responsible for what they say?” Michener explained that he was the victim of a faith healer as a child and was prevented from receiving medical help when his left leg was severely burned. “Thirty years later I am still trying to repair the damage ...”.<sup>16</sup>

The potential for harm exists whether the words relied upon consist of advice or prayer from a faith healer for a physical medical condition, or pastoral counselling from a cleric for a serious mental disorder, such as depression.

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<sup>14</sup> *Parliamentary Debates (Hansard)* Psychologists Bill, Second Reading, 19 April 1989, Mr Collins, Minister for Health and Minister for Arts, 6796-6797.

<sup>15</sup> Scharwz, T. 1993 *Faith or Fraud? Healing in the Name of God* Zondervan Publishing House Grand Rapids Michigan, 189.

<sup>16</sup> Weitz, 81.

## 10.2 Counselling which exacerbates the client's depression

Most pastoral counselling for depression is probably unlikely to be harmful in itself. Whether that is so is to some extent an empirical question. It is conceivable, however, that pastoral counselling for depression could increase a client's vulnerability by exacerbating their depression, even where the counselling does not divert or delay a client from using other treatments for depression.

That could not occur unless the client took the counselling seriously and in that sense relied upon it. Whether exacerbated depression could be compensable damage in itself, in the absence of physical injury, is considered in Appendix A.

Not every form of counselling or other intervention for depression that could foreseeably exacerbate a client's depression would constitute a breach of duty. Reasonable care does not require perfection.<sup>17</sup>

Thus even if a cleric says something in the course of pastoral counselling for depression that could foreseeably contribute to the client's depression, this will not necessarily constitute a breach of duty. There is room for debate in determining which forms of counselling should be considered unreasonable:

Deciding on which beliefs are [harmful] ... is a tricky issue heavily influenced by personal bias.<sup>18</sup>

By way of example of counselling which might be unreasonable, cross-examination of an expert witness for the plaintiff, who was a psychiatrist and a minister of religion, occurred in *Nally* as follows:

- Q. Doctor, from everything you have read about this case, it's fairly obvious, isn't it, that everyone was trying to help this boy?
- A. I would not agree with that at all.
- Q. You don't think Pastor Thomson was sincere in his efforts to help this boy?

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<sup>17</sup> *Maloney v Commissioner for Railways* (1978) 18 ALR 147 per Barwick CJ at 148.

<sup>18</sup> Koenig, 184.

- A. I think he was sincere, but ... he should have qualified himself. What he did fed that young man's depression. It set impossible standards for him. He [Thomson] was not only depressive, he had an intractable, self-defeating style. In setting high standards, he only fed his sickness. That type of counseling would drive that young man to suicide.
- Q. In other words, doctor, you don't agree with Rich Thomson's interpretation of the Bible, is that right?
- A. Probably I agree with a lot of it, but not when he uses it to hide behind to be an authority and treat a young man that is desperate for help and can't even integrate what he is saying. All he can do is use it to defeat himself over and over again. The kid was constantly being defeated by these high standards.<sup>19</sup>

The comments of the expert witness evidence the possibility that pastoral counselling could exacerbate depression. It is unclear what the witness meant in saying that Nally 'was constantly being defeated by these high standards', and how this may have contributed to Nally's suicide, or could contribute to a client's depression.

A failure to live up to high standards such as 'loving God with *all* one's heart [or] about being *perfect*' may, it has been claimed, cause emotional difficulty, anxiety or stress.<sup>20</sup> It has also been said that 'a moralistic, sin-oriented theology would not be particularly helpful to suicidal individuals',<sup>21</sup> and:

Perhaps the most frequently debated empirical hypothesis is that faith traditions in general (and, in particular, more fundamentalist Christian faith traditions) foster lower self-esteem through mechanisms of guilt, shame and sin ... [a researcher] was able to identify eighteen studies relating religion and self-esteem. A simple comparison of results across all studies indicated no clear pattern. Of the eighteen studies, eight found no relationship between religion and self-esteem, six found a positive relationship, and four found a negative relationship.<sup>22</sup>

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<sup>19</sup>Weitz, 125. The witness was Dr Bill Adams, psychiatrist and Methodist minister.

<sup>20</sup>Beck, J.R. 'Treatment of Spiritual Doubt Among Obsessing Evangelicals' (1981) 9 *Journal of Psychology and Theology* 224, 226-231, emphasis in original.

<sup>21</sup>Sullender, R.S. & Malony, H.N. 'Should Clergy Counsel Suicidal Persons?' (1990) 44 *The Journal of Pastoral Care* 203, 204.

<sup>22</sup>Hood, R.W. 'Sin and Guilt in Faith Traditions: Issues for Self-Esteem' in Schumaker, 110, 110-111.

Some of the above comments also pertain to the issue of degree of care.<sup>23</sup> In relation to duty of care it is not necessary to resolve issues regarding what might constitute unreasonable counselling.

Rather, it suffices to note the possibility, evidenced by the discussion above, that some pastoral counselling for depression could increase the vulnerability of a client by exacerbating their depression, whether or not it diverts or delays the client from using the main treatments for depression.

### **10.3 Degree and nature of increased vulnerability**

The question arises as to what type or degree of increased vulnerability, if any, would suffice to establish or support the existence of a duty of care regarding pastoral counselling for depression. Previous cases are not of direct assistance on this point. It has been said by McHugh J:

The degree and nature of vulnerability sufficient to found a duty of care will no doubt vary from category to category and from case to case ...<sup>24</sup>

What is presumably meant by his Honour is not that vulnerability will found a duty of care, but that the plaintiff's vulnerability to the defendant's conduct may do so. The potential for an increase in vulnerability due to the counselling is, it is suggested, of greater relevance than the pre-existing vulnerability of a client.

The potential of pastoral counselling for depression, if relied upon, to divert or delay a client from use of the main treatments for depression is arguably a matter of sufficient significance to favour the existence of a duty of care. Whether that is so is a matter of opinion.

That some pastoral counselling for depression could exacerbate a client's depression even where it does not divert or delay the client from using the main treatments is an additional matter which might increase the vulnerability of a client.

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<sup>23</sup> In this regard see further section 15.10.

<sup>24</sup> *Perre* at 229.

As already seen, 'reliance' as a factor which will favour the existence of a duty of care in the context of pastoral counselling for depression is not actual reliance, but rather knowledge by the cleric of the likelihood of reliance, or knowledge the cleric should have had of the likelihood of reliance, where such reliance if it occurred would be reasonable.<sup>25</sup>

Consequently, an actual increase in vulnerability due to actual reliance is not required. The relevant consideration is not that pastoral counselling for depression would *always* increase the vulnerability of a client, but that where there is potential for reliance, there is potential for increased vulnerability.

## **Conclusion**

Vulnerability may arise from reliance. Where clergy provide pastoral counselling for depression, a client could rely on it and thereby be diverted or delayed from using the main treatments for depression.

The client could thus experience unnecessarily prolonged depression if the pastoral counselling was ineffective, and thereby be more vulnerable or at increased risk by reason of the pastoral counselling for depression, in the sense of being more vulnerable to loss or injury from the depression.

The potential for pastoral counselling to increase the vulnerability of the client in this manner, if reasonable care is not taken, is arguably a matter of sufficient significance to favour the existence of a duty of care. Whether that is so is a matter of individual judgment. In addition, some pastoral counselling for depression could exacerbate the depression of a client, which would also seem to favour a duty of care.

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In the next chapter the general principle of negligence law that the defendant must be able to reasonably foresee harm to the plaintiff as a consequence of an act or omission will be considered, as it relates to pastoral counselling for depression.

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<sup>25</sup>Section 7.3.

## REASONABLE FORESEEABILITY

### Introduction

In this chapter the concept of reasonable foreseeability as it relates to pastoral counselling for depression is considered. It is axiomatic that the defendant must be able to reasonably foresee harm to the plaintiff as a consequence of an act or omission in order for a duty of care to exist.<sup>1</sup>

That is not sufficient however: ‘as five members of the Court have recently held, foresight of harm does *not* provide a remedy for all who suffer negligently inflicted harm’.<sup>2</sup>

‘Strictly speaking, even in the case of injury to the person or property, the foreseeability of physical harm is not sufficient to impose an obligation on a person to take reasonable steps to avoid a risk of that harm’.<sup>3</sup>

### 11.1 The test for reasonable foreseeability

The question to be asked in relation to duty of care and reasonable foreseeability is:

Was it reasonably foreseeable to the alleged wrong-doer that particular conduct or an omission on its part would be likely to cause harm to the person who has suffered damage or a person in the same position?<sup>4</sup>

Prior to the *CLA*, a risk was reasonably foreseeable provided that it was ‘not far-fetched or fanciful’.<sup>5</sup> The *CLA* states that a person is not negligent unless the risk in question is ‘not insignificant’.<sup>6</sup>

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<sup>1</sup> Both at common law and under section 5B (1) of the *CLA*, which states that ‘a person is not negligent in failing to take precautions against a risk of harm unless (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known)’.

<sup>2</sup> *Tame* per Hayne J at 402, emphasis in original, citing *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1577.

<sup>3</sup> *Ibid* per Gaudron at 339.

<sup>4</sup> *Pyrenees* per Kirby J at 419.

<sup>5</sup> Eg. *Nagle v Rottnest Island Authority* (1993) 177 CLR 423 per Mason CJ, Wilson, Deane and Dawson JJ at 431: ‘A risk may constitute a foreseeable risk even though it is unlikely to occur. It is enough that it is not far-fetched or fanciful’. To the same effect see *Wyong Shire Council v Shirt* (1980) 146 CLR 40 per Mason J at 47 (Stephen & Aickin JJ agreeing).

<sup>6</sup> Section 5B (1) (b).

‘The meaning of the phrase “not insignificant” is incapable of any more precise definition’.<sup>7</sup> Parliament intended it to connote a higher degree of foreseeability than the phrase ‘not far-fetched or fanciful’, but how much higher is uncertain:

A risk has to be not insignificant before a court can find it was reasonably foreseeable. This will send a clear message to the courts that, under the current common law, liability for insignificant risk is too easily imposed ... people should only have to guard against risks that are a real possibility.<sup>8</sup>

The plaintiff need not show that the precise manner in which the injury complained of was reasonably foreseeable:

[I]n order to establish the prior existence of a duty of care ... it is not necessary for the plaintiff to show that the precise manner in which his injuries were sustained was reasonably foreseeable; it is sufficient if it appears that injury to a class of persons of which he was one might reasonably have been foreseen as a consequence ... it would be quite artificial to make responsibility depend upon ... the capacity of a reasonable man to foresee damage of a precise and particular character or upon his capacity to foresee the precise events leading to the damage complained of.<sup>9</sup>

The foreseeability inquiry as it relates to duty of care is a generalised one:

It is, we think, sufficient in the circumstances of this case to ask whether a consequence of the same general character as that which followed was reasonably foreseeable as one not unlikely to follow.<sup>10</sup>

The approach to foreseeability, as applied to the ascertainment of the existence of a duty of care, is that stated by this Court in *Wyang Shire Council v Shirt*. Where what is in question is the existence of a duty of care, the decision maker is obliged to conduct a “generalised inquiry” to ask whether a reasonable person in the defendant’s position would have foreseen that the conduct involved a risk of injury to the plaintiff, or to a class of persons including the plaintiff.<sup>11</sup>

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<sup>7</sup> Villa, 33.

<sup>8</sup> *Parliamentary Debates (Hansard)* Civil Liability Amendment (Personal Responsibility) Bill, Second Reading, 19 November 2002, Mr Egan, Treasurer, Minister for State Development, 6896, 6896. The phrase ‘not insignificant’ relates to foreseeability of risk, and not to whether the defendant should have sought to avert the risk, as the *CLA* specifies the matters to be considered in determining whether the defendant should have done so - see section 13.1.

<sup>9</sup> *Chapman v Hearse* (1961) 106 CLR 112 per Dixon CJ, Kitto, Taylor, Menzies and Windeyer JJ at 120-121.

<sup>10</sup> *Ibid* 119.

<sup>11</sup> *Crimmins* per Kirby J at 81. In *Wyang Shire Council* it was said by Mason J at 47: ‘Foreseeability of the risk of injury and the

[T]he foreseeability inquiry at the duty ... stage ... depends upon proof that the defendant and plaintiff are so placed ... that it is reasonably foreseeable as a possibility that careless conduct of *any kind* on the part of the former may result in damage of *some kind* to the person or property of the latter.<sup>12</sup>

The *CLA* now sets out a separate foreseeability requirement in relation to duty of care and mental harm, involving foresight that ‘a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken’.<sup>13</sup> This requirement is addressed in section 17.10 and Appendix A.

## 11.2 Foreseeability and advice or information

In relation to provision of advice or information, damage occurs not directly, but through reliance:

[D]amage flows ... from the plaintiff’s reliance on the statement and his action or inaction which produces consequential loss.<sup>14</sup>

Regarding the provision of advice or information, therefore, questions of reliance and reasonable foreseeability of harm are ‘closely related’:

In relation to the giving or advice or information, questions of reliance and actual foresight of the possibility of harm ... or ... the foresight that a reasonable person would have ... are closely related.<sup>15</sup>

In such a situation, it can be ‘more difficult’ to apply the requirement of reasonable foreseeability, as members of the Court have recognised:

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likelihood of that risk occurring are two different things. I am of course referring to foreseeability in the context of breach of duty, the concept of foreseeability in connexion with the existence of the duty of care involving a more generalized inquiry’.

<sup>12</sup> *Minister v San Sebastian Pty Ltd* [1983] 2 NSWLR 268 per Glass JA at 295, emphasis in original.

<sup>13</sup> Section 32.

<sup>14</sup> *San Sebastian* per Gibbs CJ, Mason, Wilson & Dawson JJ at 353.

<sup>15</sup> *Perre* per Gleeson CJ at 194.

[I]t is more difficult to apply the standard of reasonable foreseeability to the consequences which flow from the making of a statement than it is to apply that standard to the consequences which flow from acts. This is because damage flows, not immediately from the defendant's act in making the statement, but from the plaintiff's reliance on the statement and his action or inaction which produces consequential loss.<sup>16</sup>

As seen in the previous chapter, in order for counselling to have any significant effect, either positive or negative, the client would have to rely on it. Therefore where pastoral counselling for depression is provided, the situation as to foreseeability resembles that regarding provision of information or advice, in that the possibility of reliance must be foreseen. This will be discussed in the next section.

### **11.3 Foreseeability and pastoral counselling for depression**

What must be reasonably foreseeable is the possibility of reliance on the pastoral counselling for depression by the client, and that the reliance could lead to harm, not merely that depression could harm a client.

'There may be considerable scope for disagreement as to what is reasonably foreseeable',<sup>17</sup> thus what is foreseeable to a reasonable cleric is a matter of opinion. Arguably, a reasonable cleric could foresee the possibility of reliance on pastoral counselling for depression.<sup>18</sup>

It is also arguable that a reasonable cleric could foresee that a client who relies on pastoral counselling for depression may, if not referred to other practitioners, be diverted or delayed from using other treatments and thus experience unnecessarily prolonged depression if the pastoral counselling is ineffective.

There is no need for a reasonable cleric to be able to predict the precise way in which the client could be diverted or delayed from using other treatments for depression, or the precise treatments for depression which the client could be diverted or delayed from using in order for the test for reasonable foreseeability to be satisfied.

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<sup>16</sup>*San Sebastian* per Gibbs CJ, Mason, Wilson & Dawson JJ at 353.

<sup>17</sup>Derrington, 595.

<sup>18</sup>See also section 8.2 as to a cleric's knowledge of the likelihood of reliance.

Alternatively, it could be argued that it is foreseeable to a reasonable cleric that provision of certain forms of counselling could exacerbate a client's depression if relied upon.<sup>19</sup>

The consequences of depression, and therefore of depression which is unnecessarily prolonged or exacerbated could include, for example, physical injury from a suicide attempt.

In the next section the reasonable foreseeability of the risk of a suicide attempt will be considered. If that risk was foreseeable to a reasonable cleric as a consequence of a want of care this would suffice to satisfy the requirement of reasonable foreseeability regarding duty of care.

#### **11.4 Foreseeability of the risk of suicide attempt**

A reasonable cleric would not be credited with the same powers of foresight in relation to the risk of suicide of a depressed client as a mental health professional.

Even so, it could be argued that the mere fact that a reasonable cleric perceives a client to be depressed, either in the sense of major depressive disorder or bipolar disorder, or in the sense of serious depression if the cleric is not aware of those more precise diagnostic categories, would make the possibility of a suicide attempt foreseeable to a reasonable cleric as a consequence of a want of reasonable care.

According to Williams JA in the Queensland Court of Appeal, it is 'difficult to conclude' that suicide attempt is not a foreseeable consequence of depression:

[T]he depressed person may "do what depressed persons are apt to do, namely, to attempt suicide". If the depression is foreseeable then it is difficult to conclude that suicide as a result of that depression is not foreseeable.<sup>20</sup>

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<sup>19</sup> Such as those discussed in sections 10.2 and 15.10.

<sup>20</sup> *Lisle v Brice* (2001) 34 *Motor Vehicle Reports* 206 at 218. A suicide attempt would be all the more foreseeable if the client expressly says they are suicidal, discusses death, has made a prior suicide attempt, has a family history of suicidal behaviour, or possesses firearms.

Williams JA was quoting from a comment made by Mahoney JA in the New South Wales Court of Appeal:

[N]egligence may cause injuries to the plaintiff which make him deeply depressed and that depression may lead him to do what depressed persons are apt to do, namely, to attempt suicide.<sup>21</sup>

The risk of a suicide attempt by a depressed client would therefore appear to be a ‘not insignificant’ risk. While definitive prediction of suicide is difficult or impossible, even for mental health professionals,<sup>22</sup> definitive predictions are not needed. As Kaufman J said in *Nally*:

The point, which the majority persistently misperceives, is not that Pastors Rea or Thomson or anyone else should have known that Nally would, in fact, commit suicide. The point rather, is ... whether defendants knew or should have known that suicide was a ... possibility ...<sup>23</sup>

## Conclusion

In this chapter the general principle that the defendant must be able to reasonably foresee harm to the plaintiff as a consequence of an act or omission by the defendant in order for a duty of care to arise has been considered.

In the context of pastoral counselling for depression, harm may arise from reliance. Arguably, a reasonable cleric could foresee the possibility of reliance on pastoral counselling for depression, and that a client who relies on pastoral counselling for depression may not use other treatments for that reason and thus experience unnecessarily prolonged depression if the pastoral counselling is ineffective.

Alternatively, it could be argued that it is foreseeable to a reasonable cleric that provision of some forms of counselling could exacerbate a client’s depression if relied upon.<sup>24</sup>

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<sup>21</sup> *NSW Insurance Ministerial Corporation* at 296.

<sup>22</sup> The *APA Guideline* states: ‘it should be kept in mind that the ability to predict suicide attempts and completed suicide is poor, with both many false positives (i.e., patients who appear more likely to make attempts or complete suicide but who do not) and false negatives (i.e., patients who appear less likely to make attempts or complete suicide but who do not’, 7.

<sup>23</sup> 253 Cal. Rptr 97 (Cal. 1988) 97, 114.

<sup>24</sup> Such as those discussed in sections 10.2 and 15.10.

A reasonable cleric would not be credited with the same powers of foresight in relation to the risk of suicide of a depressed client as a mental health professional.

Even so, it could be argued that where a reasonable cleric provides pastoral counselling for depression, perceiving the client to be depressed, the possibility of a suicide attempt is foreseeable as a consequence of the client's reliance if the pastoral counselling is ineffective.

A definitive prediction of suicide is not needed. The test for reasonable foreseeability does not require the plaintiff to show that the precise manner in which the injury complained of was sustained was reasonably foreseeable. There is no need that a suicide attempt be likely, or that the precise events leading to the suicide attempt be foreseen. The risk of suicide attempt by a client is, it is submitted, not an insignificant risk.

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In the next chapter it is argued that the 'pastoral' nature of pastoral counselling for depression does not preclude the existence of a duty of care.

## Chapter 12

### THE PASTORAL NATURE OF THE COUNSELLING

#### Introduction

In *Nally* the majority of the Californian Supreme Court, while not defining ‘pastoral’, emphasised the pastoral nature of the counselling in concluding that the defendants had not been under a duty of care:

In essence, the defendants held themselves out as *pastoral* counselors - not as professional, medical or psychiatric counselors.<sup>1</sup> (emphasis in original)

In chapter four the ‘pastoral’ nature of pastoral counselling for depression was defined by reference to a number of indicia. This chapter argues that in Australia the pastoral nature of counselling does not preclude a duty of care. The first indicium, that the cleric is a non-professional counsellor, was considered in chapter eight,<sup>2</sup> and does not in itself preclude a duty of care.

#### 12.1 The counselling is provided free of charge

That no fee is charged does not preclude a duty of care. It would not preclude a conclusion that a cleric knew or should have known that a client was likely to rely on the counselling, or that such reliance was reasonable. It is a relevant factor in the consideration of those questions, but not of great significance.

Fisher and MacFarlane stated in *Churches, Clergy and the Law* that the absence of a fee will not preclude a duty of care:

A church would owe a duty of care ... to individuals who come for counselling at least so far as the relationship of counsellor and client is concerned (even if no fee or charge is made).<sup>3</sup>

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<sup>1</sup> 253 Cal. Rptr 97 per Lucas CJ at 100; Mosk, Panelli, Arguelles and Eagleson JJ concurring (Cal. 1988).

<sup>2</sup> See section 8.1.

<sup>3</sup> Fisher & MacFarlane, 169.

In an English case, *Kitchen v Royal Air Force Association & Others*, solicitors who acted pro bono were held liable in negligence, it being said by Lord Evershed MR:

I quoted a little time ago Mrs Kitchen's observation, "I suppose I am just a charity case", and even if [the defendants] were not negligent (as I think they clearly were) ... there is truth, sad and ironical though it may be, in what Mrs Kitchen said. This is not, perhaps, the first time and, perhaps, will not be the last time that disaster has been the product of amiable intention where benevolence has not been backed by effort. It is tragically clear that [the defendants] never ... applied ... their minds to what their obligations were in the way they would have done had they been instructed for reward ...<sup>4</sup>

*Kitchen* was cited approvingly by Barwick CJ in *MLC*,<sup>5</sup> whose judgment in that case has been affirmed by the Court.<sup>6</sup> Other members of the Court have made comments to similar effect. For example:

No doubt a doctor who gratuitously gives medical advice to a sick man is bound to exercise due care in giving that advice.<sup>7</sup>

The negligent performance of a service, even if it be undertaken without consideration, gives rise to liability in negligence, if the person for whose benefit the service is performed relies upon that service.<sup>8</sup>

## **12.2 The counselling is based wholly or primarily on religion**

Counselling for depression does not remain on a religious or spiritual level because it is based on religion. It has implications for the client's temporal welfare. That counselling is based on religion does not mean it is unreasonable for a client to rely on it, or that a cleric would not know or could not be expected to know that a client is likely to rely on it.

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<sup>4</sup> [1955-1995] Professional Negligence and Liability Reports 18 at 21.

<sup>5</sup> *MLC* per Barwick CJ at 567.

<sup>6</sup> See section 7.1.

<sup>7</sup> *MLC* per Owen J at 621.

<sup>8</sup> *Giannarelli* per Mason J at 555.

It is also significant that clergy tend to present the Bible as being inspired by God, and that it contains material which a client could think offers a solution to depression. For example:

Come to me all you who are weary and burdened, and I will give you rest.<sup>9</sup>

Whoever drinks the water I give him will never thirst.<sup>10</sup>

I am the way and the truth and the life.<sup>11</sup>

A medical practitioner who did nothing other than advise patients to read a religious text and pray to get well would not have no duty of care by reason of the religious nature of the advice. A mental health professional who employed religious methods to treat a depressed person would nonetheless owe a duty of care. As counsel for the plaintiffs said in *Nally* in argument before the Californian Supreme Court:

“What about pure Pastoral Counseling centers, the state has a lot of them?” These centers had ... trained professionals. Do these centers escape liability because they are pastoral counselors? “I would think not”, said [counsel for the plaintiffs], adding that if that were the case, every psychiatrist and psychologist would be ordained, certified as a minister or otherwise affiliated with a church to escape liability.<sup>12</sup>

Nor should a cleric who provides pastoral counselling for depression avoid a duty of care by reason of the religious nature of the counselling.

The religious nature of the counselling seems to have been treated as telling against a duty of care by the majority of the Californian Supreme Court in *Nally*.<sup>13</sup> This was, it is submitted, a misguided position to take, and it would be erroneous to take that position in Australia.

There is nothing talismanic about the religious nature of pastoral counselling for depression that protects clergy from the possibility of being subject to a duty of care, for reasons indicated in this section.

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<sup>9</sup> *Holy Bible*, Matthew 11:28 (New International Version 1995 Hodder & Stoughton London).

<sup>10</sup> *Ibid* John 4:13.

<sup>11</sup> *Ibid* John 14:6.

<sup>12</sup> Paraphrased in Weitz, 177.

<sup>13</sup> See section 1.1.

### 12.3 The client may anticipate or desire counselling based on religion

Client ‘attitudes, beliefs [and] preferences’ should be considered by those seek to help depressed persons.<sup>14</sup> Be that as it may, client preference, although relevant, cannot be the sole determinant of what can reasonably be expected of those who provide counselling for depression.

This is because depressed clients may be unable to make balanced judgments, may lack desire to seek appropriate care, and may lack knowledge of the treatment options for depression and the implications of not seeking appropriate treatment, as already seen.<sup>15</sup>

Even if a cleric and a client expressly agree, or make a contractual arrangement, that the cleric will only provide counselling based on religious ideas, a court may conclude that the agreement or contract is not definitive of the degree of care required. Callinan J pointed out:

If ... the particular circumstances must be carefully examined by the Court before it can be determined what is the scope and extent of the duty of care in a particular case, it is rather unlikely that contracting parties would always be able in their contracts, express or implied, precisely to define the relevant scope and extent of their respective obligations.<sup>16</sup>

If a contract or other agreement is unlikely to be conclusive of the degree of care required, it could hardly be conclusive of whether a duty of care arises at all.

Of course, not all clients of clergy will anticipate or desire counselling based on religion - some may just want help of *some* kind, and some may not know what to expect. If a client expects that a cleric has the ability to use a non-religious intervention for depression, for example cognitive behavioural therapy, and the cleric fails to correct the client’s misapprehension this may strengthen the case for a duty of care or a higher degree of care than would otherwise be the case.

It is unnecessary to pursue this possibility for the purposes of the thesis; it suffices to note that a client’s anticipation of or desire for counselling based on religion will not preclude a duty (or be conclusive of the degree of care required: see section 13.10.4).

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<sup>14</sup> *NHMRC Guidelines*, 50.

<sup>15</sup> See section 3.10.

<sup>16</sup> *Astley* at 51.

## **12.4 Objective of spiritual welfare**

Where the objectives of counselling do not include solving the problem of the client's depression then such counselling is beyond the scope of the thesis.

If the objectives include both this objective and the spiritual welfare of the client then these objectives will either be consistent or inconsistent. If a cleric views the spiritual welfare of a client as coincident with the objective of the solving the problem of the client's depression then it could not make any difference to whether the cleric owes a duty of care.

On the other hand a cleric may view the two objectives as inconsistent. To use a hypothetical example which it is not asserted would frequently apply in Australia, a cleric might think 'suffering will bring the client closer to God therefore I will allow the client to remain depressed for the time being'.

As already seen, religious belief is not a solvent of legal obligation,<sup>17</sup> and depression is a major risk factor for suicide.<sup>18</sup> Therefore any perceived inconsistency of temporal and spiritual welfare of the client is not a matter which a court would be likely to consider relevant to whether the postulated duty of care exists.

## **12.5 No detailed exploration of past experience, and no attempt at deep emotional understanding or restructure of the client's personality**

The depth of the counselling has limited bearing on whether it would be reasonable for a client to rely on counselling or on whether a cleric knew or should have known a client was likely to rely on the counselling.

The degree of 'depth' of counselling activity, while perhaps a distinguishing feature of some types of counselling or psychotherapy, is therefore of limited relevance to the question of whether a duty of care arises.

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<sup>17</sup>Section 5.10.

<sup>18</sup>Section 3.10.

It could perhaps be said that where counselling involves detailed questioning designed to ensure a comprehensive coverage of problems and symptoms, or an attempt at deep emotional understanding, the client may be more likely to rely on the counselling than otherwise, but this is not a major point. It is not only this type of counselling that could be relied upon.

It is of background importance that mental health professionals do not always seek deep emotional understanding or to restructure the personality of the client. Neither the *NHMRC Guidelines* nor the *APA Guideline* mention 'deep emotional understanding' or the 'restructure of the client's personality' as useful to the treatment of depression.

Cognitive behavioural therapy does not involve attempts at deep emotional understanding,<sup>19</sup> but it would not be suggested that a psychologist who employed cognitive behavioural therapy does not owe a duty of care.

## **12.6 The relationship is short-term**

When describing the circumstances in which the law will impose a duty of care for provision of advice or information in *MLC*, Barwick CJ did not stipulate that the relationship between the speaker and the recipient must be long-term. Short-term counselling can attract a duty of care. A duty of care can arise from a single transaction:

A duty to act to prevent foreseeable injury to another may arise when a transaction - which may be no more than a single act - has been undertaken by the alleged wrongdoer and that transaction - or act - has created or increased the risk of that injury occurring.<sup>20</sup>

Pastoral counselling for depression could be relied upon from the initial scheduled session, while it continues, and for long after it ceases. Reliance on short-term counselling may be reasonable. There is a need to take care when providing the short-term counselling as its effects will not necessarily be insignificant or short-term: 'the short-term nature of most pastoral counselling does not mean that its results are necessarily superficial'.<sup>21</sup>

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<sup>19</sup> See section 3.8.

<sup>20</sup> *Sutherland Shire Council* per Brennan J at 479.

<sup>21</sup> Clinebell, 1966, 85.

## Conclusion

In chapter four the 'pastoral' nature of pastoral counselling for depression was described by reference to a number of indicia. These indicia to a large extent distinguish such counselling from other counselling, but do not preclude a duty of care from arising.

A duty of care may arise for gratuitous counselling. The fact that pastoral counselling for depression is based on religious ideas and may include as one of its objectives the spiritual welfare of the client does not preclude a duty of care. Nor does the fact that a client anticipates or desires the counselling to be based on religion.

The fact that counselling does not involve detailed exploration of past experience, or an attempt at deep emotional understanding or restructure of the client's personality does not mean that a duty of care may not arise. Short-term counselling may attract a duty of care.

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It has been argued to this point that consideration of whether the postulated duty of care will arise should proceed by reference to the following questions:

(1) Whether the cleric knew, or a reasonable cleric would have known, of a likelihood of a client relying on the pastoral counselling for depression, if such a likelihood existed. Chapter eight addressed this question.

(2) Whether such reliance, if it occurred, would be reasonable. This was also discussed in chapter eight.

(3) Whether pastoral counselling for depression has the potential to increase the vulnerability of the client, if reasonable care is not exercised. This issue was dealt with in chapter ten.

(4) Whether harm to the client could be foreseen by a reasonable cleric as a result of an act or omission when providing pastoral counselling for depression. This was discussed in chapter eleven.

If the answer to any of these questions is negative, it is submitted that the postulated duty of care will not arise. It would therefore be unnecessary to undertake consideration of policy or of degree of care. If the answer to each of those questions was positive, it would be necessary, it is submitted, to consider policy.<sup>22</sup>

Discussion of policy can take place in a more informed manner if the possible degree of care is kept in mind, in that regard can be had to the size of the burden which reasonable care may impose on clergy. In the next chapter, therefore, consideration of the degree of care issue will commence. The discussion of degree of care will continue in chapters fourteen and fifteen, prior to examination of policy in chapter sixteen.

That is not to say the degree of care issue is not important in its own right; rather it is to acknowledge that degree of care is relevant to consideration of the duty of care issue:

The analytical divisions and subordinate questions are all designed to bring the mind ... to the ultimate issue presented by the many cases that have followed *Donoghue v Stevenson*. They address attention to whether, in all the circumstances of the case, it is reasonable to impose a legal duty of care of the postulated character upon the alleged tortfeasor. In the search for consistent decision-making, lawyers endeavour to segregate the concepts of duty, scope and breach. Yet in truth they represent, ultimately, component parts of a unified notion that must be constantly brought back to the touchstone of reasonableness.<sup>23</sup>

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<sup>22</sup> See chapter 16.

<sup>23</sup> *Dovuro Pty Ltd v Wilkins* (2003) 215 CLR 317 per Kirby J at 349-350.

## Chapter 13

### DEGREE OF CARE

#### Introduction

If a duty of care arises, it is necessary to specify the degree of care required. Reasonable care must be exercised. The question is what this means in the context of clergy who provide pastoral counselling for depression. Fisher and MacFarlane stated in *Churches, Clergy and the Law*:

[T]here is a subjective overlay and reasonableness here relates to the category of persons ... to which the defendant belongs. Thus a doctor must exercise the care of a reasonable and competent doctor; the motor vehicle driver must exercise the care of a reasonable and competent driver; the priest must exercise the care (so far as his or her duties are concerned) of a reasonably competent priest; a church must exercise the care of a reasonable ... occupier of premises ... and church camp leaders must exercise the care of reasonable and competent leaders.<sup>1</sup>

Clergy who provide pastoral counselling do not belong to the category of pastoral counsellors, nor simply to the category of clergy. They fall within the category of clergy who provide pastoral counselling for depression. They must exercise the degree of care of a reasonable person in the position of a cleric ('a reasonable cleric') who does so.

As will be seen in this chapter, both the *CLA* and the common law mean that the indicia by reference to which the pastoral nature of the counselling has been described herein are not the only matters to be considered when determining the degree of care of a cleric who provides pastoral counselling for depression.

Rather, the matters to which the *CLA* and / or the common law direct attention include the circumstances of the particular case; the foreseeability, probability and gravity of harm which could arise from a negligent act or omission; the burden of taking precautions to avoid the risk of harm; church codes or rules; and the opinion of relevant experts. This law will be applied in the next chapter.

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<sup>1</sup>Fisher & MacFarlane, 171.

### 13.1 Section 5B of the *CLA*

Section 5B of the *CLA* provides:

(1) A person is not negligent in failing to take precautions against a risk of harm unless (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known) and (b) the risk was not insignificant, and (c) in the circumstances, a reasonable person in the person's position would have taken those precautions (2) in deciding whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things); (a) the probability that the harm would occur if care is not taken; (b) the likely seriousness of the harm; (c) the burden of taking precautions to avoid the risk of harm; and (d) the social utility of the act that creates the harm.

It was noted in section 11.1 that section 5B(1)(b) varies the test for reasonable foreseeability. Apart from this change, section 5B essentially restates the common law, which includes the following aspects:

The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position.<sup>2</sup>

Where a duty of care arises ... the standard of care ... is that which is reasonable in the circumstances. It has been emphasised in many cases that the degree of care under that standard ... varies with the risk involved and that the risk involved includes both the magnitude of the risk of an accident happening and the seriousness of the potential damage if an accident should occur.<sup>3</sup>

In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff.<sup>4</sup>

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<sup>2</sup> *Wyong Shire Council* per Mason J at 48, (Stephen & Aickin JJ agreeing).

<sup>3</sup> *Burnie Port Authority v General Jones Pty Ltd* (1994) 179 CLR 520 per Mason CJ, Deane, Dawson, Toohey & Gaudron JJ at 554.

<sup>4</sup> *Wyong Shire Council* per Mason J at 47 (Stephen & Aickin JJ agreeing).

## 13.2 Section 5O of the *CLA*

Section 5O (1) of the *CLA* specifies the standard of care for ‘professionals’ as follows:

A person practising a profession (“a professional”) does not incur liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

Peer professional opinion will not be relevant unless rational:

[P]eer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.<sup>5</sup>

‘Section 5O talks in terms of persons “practising a profession”, a formulation that would seem to exclude trades and other non-professional groups’.<sup>6</sup>

Neither the *CLA* nor the *Civil Liability Regulations* provide a more detailed definition of ‘professional’. The *Review of the Law of Negligence* does not define the term.<sup>7</sup> In the context of a trade practices case it has been suggested:

[R]eferences to profession and professional activity at least include ... medicine, dentistry and the law ... They may ... include, for example taxation consultants, brokers, teachers and conceivably ... mediators. One might distinguish mediation done casually and as an adjunct to another activity, such as a Minister of Religion or Rabbi and mediation done as a principal activity by a trained mediator suitably accredited. Thus the same activity carried on in an untrained or ad hoc way lacking any accreditation, code of ethics or special competence and training would fall outside the notions of profession and professional activity.<sup>8</sup>

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<sup>5</sup>Section 5O (2).

<sup>6</sup>Villa, 93.

<sup>7</sup>*Review of the Law of Negligence*, 237-240: ‘Definitions’.

<sup>8</sup>*Prestia v Aknar* (1986) 40 NSWLR 165 per Santow J at 189.

After referring to the above passage, Villa stated:

It seems that a person who undertakes a particular activity that is characteristically undertaken by a member of a profession but who, in fact, is not a member of that profession ... is not “practising a profession”.<sup>9</sup>

A definition of ‘professional’ adopted in a trade practices case is not conclusive of the interpretation of the phrases ‘professional service’ or ‘the practising of a profession’ in the *CLA*. The better view nonetheless is that pastoral counselling for depression as defined herein does not constitute the provision of a ‘professional service’ or the ‘practising of a profession’, thus section 5O of the *CLA* does not apply.

Moreover, interpreting the *CLA* as inapplicable to practitioners who lack training or competence in the area in which they provide the service is arguably sensible.

This is because it could conceivably be appropriate to compel judges to follow widely accepted peer opinion where the practitioners concerned are trained and competent in the provision of the service in question, provided the opinion is not irrational, but the same could not be said in relation to peer opinion of practitioners who lack relevant training or competence.

### **13.3 *Rogers v Whitaker***

In *Rogers v Whitaker*<sup>10</sup> the Court considered whether the defendant ophthalmic surgeon was obliged to warn the plaintiff of the risk of developing blindness in her left eye consequent upon surgery to restore sight to her right eye. That risk materialised.

The defendant argued that since there evidence from a reputable body of medical practitioners that in the circumstances of the case they would not have warned the plaintiff of the risk, he had not been negligent in failing to warn the plaintiff.

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<sup>9</sup> Villa, 94.

<sup>10</sup> (1992) 175 CLR 479.

The Court unanimously rejected that argument, holding that the degree of care required 'is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade',<sup>11</sup> though such opinion is relevant.

Section 5O displaces *Rogers* in relation to the provision of a professional service, except that *Rogers* continues to apply where a professional fails to warn of a risk of death or injury associated with the provision of a professional service.<sup>12</sup>

It would appear that *Rogers* continues to operate in relation to trades.<sup>13</sup> Whether pastoral counselling for depression is viewed as a trade or not, it is hardly likely that the Court would treat an opinion widely accepted by non-professional counsellors as conclusive.

#### **13.4 The opinion of relevant experts**

The matters specified by section 5B of the *CLA* are not an exhaustive list of the matters which may be relevant to degree of care. Rather, those matters are to be considered 'amongst other relevant things'.<sup>14</sup>

There remains scope, therefore, to consider the opinions of pastoral counselling experts and mental health professionals. Since section 5O does not apply, such opinion need not be from within Australia.

It is not to the point that such experts cannot be equated with clergy, as there is no requirement that they be peers of clergy. That is not to imply that the degree of care required of clergy is that which would apply to one or more of the various types of mental health professionals.

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<sup>11</sup> *Ibid* per Mason CJ, Brennan, Dawson, Toohey & McHugh JJ at 487, similarly see Gaudron J at 493.

<sup>12</sup> Section 5P.

<sup>13</sup> Section 13.2.

<sup>14</sup> Section 13.1.

### 13.5 Church codes or rules

Section 5B also leaves scope for church rules or codes of conduct to be considered. Such rules or codes are relevant, if they refer to a potentially applicable requirement, but are not definitive of the degree of care required.<sup>15</sup>

Thus the fact that a church code or rule supports or requires the taking of a particular measure would to some extent favour imposition of the measure as a legal requirement, but is not conclusive. Churches or other groups may set for themselves high ethical standards which may exceed legal requirements.

### 13.6 The circumstances of the case

Members of the Court have made it clear that attention must be paid to the circumstances of the case in ascertaining the degree of care required. For example *McHugh*, *Kirby*, *Hayne* and *Callinan JJ* respectively have spoken with one voice in this regard:

Reasonable care in all the circumstances of the case is the benchmark of negligence law. No exception need or should be made for landlord's liability.<sup>16</sup>

To determine the ... scope of a duty of care requires scrutiny of the precise relationship between the parties.<sup>17</sup>

What is reasonable must be judged in the light of *all* the circumstances.<sup>18</sup> (emphasis in original)

[S]cope of duty will always depend on the particular circumstances ...<sup>19</sup>

The *CLA* has not altered this position.

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<sup>15</sup>This is arguably supported by the following passage from Barwick CJ in relation to sporting clubs: 'The rules of the sport or game [may constitute a relevant circumstance] but, in my opinion, they are neither definitive of the existence nor of the extent of the duty; nor does their breach or non-observance necessarily constitute a breach of any duty found to exist' - *Rootes* at 385. There does not appear to be a sound basis in distinguishing between churches and sporting clubs in this regard.

<sup>16</sup>*Jones* per *McHugh J* at 16.

<sup>17</sup>*Crimmins* per *Kirby J* at 82.

<sup>18</sup>*Romeo v Conservation Commission (NT)* (1998) 192 CLR 431 per *Hayne J* at 488.

<sup>19</sup>*Astley* per *Callinan J* at 51.

### 13.7 The general objective standard of the law of negligence is not abandoned

In *Cook v Cook*, concerning the degree of care an unlicensed novice driver owed to a passenger who knew of her inexperience, Mason, Wilson, Deane & Dawson JJ said:

[T]o borrow the example cited by Latham CJ in *Joyce's Case* (at 46), if a person were ... to allow a blacksmith to seek to mend his watch, the blacksmith would be required to act as a reasonable person should in the circumstances, though he should not be subject to the high standard of care which would be required of a professional watchmaker. The reason for that is not that the objective general standard required by the law of negligence is abandoned. It is that the more detailed definition of the content of that objective standard will depend upon the relevant relationship ... from which it flows and into which the reasonable person of the law of negligence must be projected; it 'is because that relation may vary that the standard of duty or of care is not necessarily the same in every case' (per Dixon J, *Joyce's Case*, at 56).<sup>20</sup>

Although this authority is not directly relevant, it supports a conclusion that where a cleric provides pastoral counselling for depression, the standard to which clergy will be held will not correspond to the standard of care applicable to a psychologist or to that applicable to some other type of mental health professional.<sup>21</sup>

The general objective standard required by the law of negligence will not be abandoned, however, and the cleric will nonetheless be required to act as a reasonable cleric who provides pastoral counselling for depression should in the circumstances or the relationship: 'the content of the duty of care in a particular case is governed by the relationship ... from which it springs'.<sup>22</sup>

### 13.8 The condition of the particular client

Where a duty of care exists a defendant must not act or omit to act whereby injury could be caused to 'the particular plaintiff in his particular circumstances'.<sup>23</sup> The degree of care required of doctors 'depends on the history and condition of the patient ... and all the other circumstances of the case'.<sup>24</sup>

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<sup>20</sup>(1986) 162 CLR 376 at 382.

<sup>21</sup>The above passage from *Cook* seems somewhat at odds with the comments by Mason and Deane JJ on standard of care, quoted in section 8.1. As the statement in *Cook* was made by a majority of the Court, preference will be given to it.

<sup>22</sup>*Hawkins* per Deane J at 579.

<sup>23</sup>*Sydney City Council* per Jacobs J at 119 (Mason and Stephen JJ agreeing).

<sup>24</sup>*Breen* per Brennan CJ at 78.

This does not mean that the degree of care required of clergy is the same as that required of doctors. Each type of practitioner will have their own degree of care, but this will depend in part on the circumstances of the case and the condition of the patient or client.

### **13.9 Presence or absence of a representation of competence**

The degree of care required of clergy who provide pastoral counselling for depression is not determined solely by reference to what they tell the client they are going to do or hold themselves out as capable of doing:

If ... the particular circumstances must be carefully examined by the Court before it can be determined what is the scope and extent of the duty of care in a particular case, it is rather unlikely that contracting parties would always be able in their contracts, express or implied, precisely to define the relevant scope and extent of their respective obligations.<sup>25</sup>

If it is unlikely that the parties can contractually specify the degree of care, it would also appear unlikely that they could do so through some non-contractual agreement or communication. Thus if a cleric holds themselves out as a non-professional counsellor, or says to a client that they will use religious methods in accordance with their religious belief, this does not mean that they could never be expected to take a non-religious measure.

### **13.10 The pastoral nature of the counselling**

The pastoral nature of the counselling is relevant, incident to application of the general objective standard of the law of negligence that a cleric who provides pastoral counselling for depression must act as a reasonable cleric should in the circumstances. The pastoral nature of the counselling does not in itself govern the degree of care required. Dixon J stated:

It is recognised that, where what is alleged against [a defendant] is failure to fulfil an obligation of care, the character in which he acted, together, no doubt, with the nature of the duties he was in the course of performing, may determine the extent of the duty of care.<sup>26</sup>

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<sup>25</sup> *Astley* per Callinan J at 51.

<sup>26</sup> *Shaw Savill and Albion Co. Ltd v The Commonwealth* (1940) 66 CLR 340 per Dixon J at 361; quoted approvingly by Gummow J

The degree of care required of clergy who provide pastoral counselling for depression cannot be defined completely objectively, merely according to the fact that an attempt is being made to solve the problem of depression.

If this was done, then clergy, general practitioners, psychologists and psychiatrists would all owe exactly the same degree of care whenever they were in the course of attempting to solve the problem of depression, which is not the case.

Yet to describe the counselling as ‘pastoral counselling’ does not wholly sum up the ‘nature of the duties’ a cleric who provides pastoral counselling for depression is ‘in the course of performing’.

‘The nature of the duties’ calls for consideration of what is being done, which is an objective criterion, not merely how it is being done, which is a more subjective criterion, in that it depends on the skill or the choices of the person doing it.

Thus the degree of care required of clergy who provide pastoral counselling for depression is partly objective and partly subjective, as suggested by *Cook* above. The ‘pastoral’ nature of the counselling has been defined herein by reference to a number of indicia,<sup>27</sup> which are discussed in turn.

### **13.10.1 The cleric is a non-professional counsellor**

The law will not tailor the degree of care required of a counsellor precisely to the training or status of the counsellor. If it did, then no training would mean no duty, which is not correct.<sup>28</sup> The law will not calibrate the degree of care expected of clergy according to fine gradations in the amount of relevant training they have had so that there would be a different degree of care for clergy of each denomination or religion.

The fact that a practitioner works on a casual or irregular basis does not, in itself, mean a lower degree of care. It would not be suggested that a medical practitioner who works on a casual basis owes a lower degree of care than other medical practitioners.

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in *Pyrenees Shire Council v Day* (1998) 192 CLR 330 at 388.

<sup>27</sup> See chapter four.

<sup>28</sup> See section 8.1.

It therefore could hardly be suggested that the degree of care expected of clergy who provide pastoral counselling for depression depends on whether they do so on an irregular or casual basis or not:

The fact that a minister is a part-time counsellor is, of course, no excuse for incompetence. There is no other aspect of a minister's work in which lack of competence can have comparable negative effects. In counselling, the pastor often deals with people at their time of greatest vulnerability.<sup>29</sup>

Reasonable care must be exercised - 'the subjective notion of personal "fault" has long been discarded in favour of the stricter, impersonal standard of how a reasonable person should have acted in the circumstances'.<sup>30</sup>

### **13.10.2 The counselling is undertaken free of charge**

When undertaken free of charge pastoral counselling for depression may be of social utility, but will be of lesser utility when reasonable care is not exercised. The social utility of the act that creates the harm is relevant to degree of care.<sup>31</sup> 'Any decision about what is, or is not, socially useful is, by its very nature contestable'.<sup>32</sup> The social utility of pastoral counselling for depression is discussed in section 16.2.

It remains to be seen whether a court would hold that it would be reasonable for a cleric to make less effort and take less care when providing free pastoral counselling for depression than if being paid, should a relevant case arise. At most, this is merely one factor to be considered.

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<sup>29</sup> Clinebell, 1966, 44.

<sup>30</sup> Fleming, 114.

<sup>31</sup> Section 5B (2) (d) of the *CLA*.

<sup>32</sup> *Tame* per Hayne J at 417.

### 13.10.3 The religious nature of pastoral counselling for depression

If the type of counselling or advice given by a counsellor is relevant to the degree of care required, this would mean that because there are hundreds of different psychotherapies (more than 450 according to one count, ‘from A (Active analytic therapy) to Z (Zareleya psychoenergetic technique)’)<sup>33</sup> there would in theory have to be hundreds of different degrees of care for psychotherapists. This would be absurd.

Further, if the type of counselling provided was relevant to the degree of care required, the spectre of a different degree of care for every counsellor would be raised, since ‘it has been suggested that there are as many schools of counseling as there are counselors’.<sup>34</sup>

If the religious nature of pastoral counselling for depression was deemed to be relevant to the degree of care required, the same sorts of consequences would occur. There would in theory need to be a different degree of care for every denomination or religion, or even a different degree of care for every different cleric who provided pastoral counselling for depression since religious belief would differ from religion to religion and from cleric to cleric.

Moreover, if the religious nature of pastoral counselling for depression was relevant to the degree of care required, by the same reasoning this would mean that a lawyer who gave religious advice for conveyancing would owe a different degree of care to other lawyers.

It would mean that a psychiatrist who gave advice based on religion would owe a different degree of care to a psychiatrist who did not. Unless such consequences are accepted as correct, it cannot convincingly be said that the religious nature of pastoral counselling for depression is relevant to the degree of care required.

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<sup>33</sup>Karasu, T.B. ‘The Psychotherapies: Benefits and Limitations’ (1986) 40 *American Journal of Psychotherapy* 324, 325.

<sup>34</sup>Van Hoose & Kottler, 8.

#### **13.10.4 The client may anticipate or desire counselling based on religion**

Client ‘attitudes, beliefs [and] preferences’ should be considered by those seek to help depressed persons.<sup>35</sup> Client expectation or preference, however, while relevant, cannot be the sole determinant of what can reasonably be expected of those who provide advice for depression.

This is because depressed clients may be unable to make balanced judgments, may lack desire to seek appropriate care, and may lack knowledge of the treatment options for depression and the implications of not seeking appropriate treatment, as already seen.<sup>36</sup>

#### **13.10.5 Objective of spiritual welfare**

If a cleric viewed a client’s spiritual welfare as consistent with the objective of relieving the client’s depression there would be no reason to temper the degree of care by reference to this factor. Even if the cleric viewed the objectives as inconsistent, this should not be considered relevant to degree of care for the same reasons this factor is not relevant to whether a duty of care exists, given in section 12.4

#### **13.10.6 No detailed exploration of past experience, or seeking of deep emotional understanding or attempts to restructure the personality**

This factor is of limited relevance to the degree of care required of clergy who provide pastoral counselling for depression, for the same reasons it is of limited relevance to whether a duty of care arises, discussed in section 12.5

#### **13.10.7 The counselling is short-term**

The short-term nature of counselling does not mean it cannot have an impact on the client. It has been said that ‘the short-term nature of most pastoral counselling does not mean that its results are necessarily superficial’<sup>37</sup> and that ‘brief modalities ... are not necessarily superficial’.<sup>38</sup>

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<sup>35</sup> *NHMRC Guidelines*, 50.

<sup>36</sup> See section 3.10.

<sup>37</sup> Clinebell, 1966, 85.

<sup>38</sup> Karasu, 1986, 327.

There is therefore as much reason to be careful when providing short-term counselling as when providing long-term counselling. Of course where pastoral counselling for depression is short-term it would not be reasonable to expect clergy to use counselling techniques that might require a lengthy counselling relationship to implement.

## **Conclusion**

To the extent that it applies to pastoral counselling for depression, the *CLA* has not significantly changed the law in relation to degree of care. It was argued in this chapter that section 50 of the *CLA*, concerning the standard of care for professionals, does not apply to pastoral counselling for depression by clergy as defined herein.

Where a cleric provides pastoral counselling for depression, the cleric will be required to act as a reasonable cleric who provides pastoral counselling for depression should in the circumstances, as the general objective standard required by the law of negligence will not be abandoned.

The pastoral nature of the counselling must be considered in determining the degree of care required, incident to application of the general objective standard that a cleric must act as a reasonable cleric who provides pastoral counselling for depression would act in the circumstances.

The question in relation to degree of care is not whether the degree of care that can be expected of a cleric who provides pastoral counselling for depression is the same as or different to that of a general practitioner, a psychologist or of some other type of mental health professional who seeks to assist a depressed person. The question is simply one of what reasonable care may require of a cleric who provides pastoral counselling for depression.

Members of the Court have made it clear on many occasions that the degree of care required depends on the circumstances of the case. Thus what it might be reasonable to impose by way of a legal duty on one cleric who provides pastoral counselling for depression to one client might not be reasonable to impose on another cleric who provides pastoral advice for depression in different circumstances to a different client.

The Court has emphasised that the foreseeability, probability and gravity of harm to the plaintiff if reasonable care is not taken are important to determination of the degree of care required. The Court has also indicated that the circumstances of the particular plaintiff and the level of expense, difficulty and inconvenience involved in alleviating the risk to the plaintiff are relevant. The *CLA* essentially restates the common law in this regard, except that it varies the test for reasonable foreseeability.

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In the next chapter, whether reasonable care would require a cleric who provides pastoral counselling for depression to comply with the duty to refer will be considered, in light of the contents of this chapter.

## DEGREE OF CARE - REFERRAL

### Introduction

This chapter considers whether the degree of care which could be expected of clergy who provide pastoral counselling for depression includes referral of the client to a general practitioner or mental health professional.

For convenience, this possible obligation has been called ‘the duty to refer’. Of course such a duty to refer will only arise, if it arises, where there is first a duty of care.

### 14.1 Doubt about which treatment might be best does not mean no duty to refer

Anti-depressant medication may have side effects, as well as a financial cost. Cognitive behavioural therapy may or may not be useful to a client. Whether a particular treatment is best for a client should be determined by application of commonsense having regard to a number of matters.<sup>1</sup>

These include the history, severity and chronicity of the depression; the individual needs, problems, resources and preferences of the client; the benefits and risks of the treatment; whether other techniques have worked or not worked in the past, including the history of the client’s response to medication for depression; and the availability and affordability of alternative practitioners and solutions.<sup>2</sup>

There are many difficulties in measuring and comparing the efficacy of the various treatments for depression.<sup>3</sup> It might be thought that if there is insufficient evidence favouring one treatment over another, then those who provide counselling for depression may recommend whatever treatment they like without fear of being successfully sued for a failure to recommend or implement effective treatment, or a failure to refer a client.

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<sup>1</sup>The *NHMRC Guidelines* refer to ‘clinical judgment (‘commonsense’)’ - at 96. Commonsense is ‘basic to the common law of negligence’ - *Cook per Mason, Wilson, Deane & Dawson JJ* at 383.

<sup>2</sup>As to this list compare the *NHMRC Guidelines*, 96; Beutler, Clarkin & Bongar, 124.

<sup>3</sup>These difficulties have been catalogued at for example Beutler, Clarkin & Bongar, 261-289 and include the dependence of data on subjective perceptions, and the complexity of human nature. It is unnecessary to detail them all here.

It has been remarked:

Psychoanalysts and other psychodynamic therapists have heretofore been almost totally immune from malpractice suits because of virtually insurmountable technical and legal reasons ... When it deals with psychiatry, the law must deal with a world of complexity, dubiety, and ... conflict about efficacy.<sup>4</sup>

In *Nally*, counsel for the defendants asked the following question:

Had the plaintiffs put on evidence as a matter of scientific certainty, medical certainty, or other empirical standards that professionals were better able to help Ken than non-professionals?<sup>5</sup>

This is the wrong question to ask. There may be doubt in a particular case as to whether a particular treatment should be implemented, and as to which treatment or treatments should be implemented *first*.<sup>6</sup> Defining reasonable care, though, does not mean ranking treatments in order of effectiveness.

The issue is not whether a general practitioner or mental health professional would certainly be more able to help a particular client than a cleric, but simply whether reasonable care would require referral.

There is little doubt that referral would increase the opportunity of clients to access a range of potentially effective treatments as well as improving the chance of an accurate diagnosis. The pastoral counselling could continue after referral.

## 14.2 Foreseeability, probability and gravity of harm

As seen in the previous chapter, the foreseeability, probability and gravity of harm which could occur from pastoral counselling for depression is relevant to the degree of care required.

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<sup>4</sup>Stone, A.A. 'The New Paradox of Psychiatric Malpractice' (1984) 311 *The New England Journal of Medicine* 1384, 1386-1387.

<sup>5</sup>Rex Lee, paraphrased by Weitz, 174.

<sup>6</sup>For example one of the main controversies is whether severely depressed patients should be given pharmacological treatments immediately, as opposed to merely receiving cognitive behavioural therapy - see eg. the *APA Guideline*, Parts A.I.B.a; A.II.B.3; C. VI & VII; *NHMRC Guidelines*, xvii.

In relation to foreseeability and degree of care, it could be argued that it is foreseeable to a reasonable cleric that if the duty to refer is breached, a client may attempt suicide.<sup>7</sup>

‘The lifetime risk of suicide among patients who have an untreated depressive disorder is nearly 20 percent’.<sup>8</sup> While clergy could not be expected to know this, a reasonable cleric would arguably know that depressed clients in general are at risk of suicide.

The foreseeability of a risk and the probability of the risk occurring ‘are two different things’.<sup>9</sup> There is no need for the cleric to assess the precise probability of a particular client attempting suicide. The probability of a client attempting suicide will vary:

[I]t is of course, manifest that the likelihood of such a happening as that which in fact occurred “will vary according to all the circumstances of the particular case”.<sup>10</sup>

The gravity of the harm which could occur from a suicide attempt is clearly very substantial. Other forms of loss or injury could also occur if pastoral counselling for depression is ineffective.<sup>11</sup>

### **14.3 The condition and characteristics of the particular client**

A depressed client may not be able to make balanced judgments regarding management of his or her depression, may lack knowledge regarding treatments, and have compromised desire and ability to seek appropriate treatment.<sup>12</sup>

This would favour referral of the client to a general practitioner or mental health professional. Were the client to be apparently psychotic or schizophrenic, or have some other mental illness or medical condition in addition to depression, this would also favour referral.<sup>13</sup>

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<sup>7</sup> Cf. the majority of the Californian Supreme Court in *Nally*: ‘One can argue that it is foreseeable that if a non-therapist counselor fails to refer a potentially suicidal individual to professional ... care, the individual may commit suicide’ - 253 Cal. Rptr. 97 (Cal. 1988), per Lucas CJ at 108; Mosk, Panelli, Arguelles and Eagleson JJ concurring.

<sup>8</sup> Beutler, Clarkin & Bongar, 303. This statistic applies to the US population.

<sup>9</sup> *Wyong Shire Council* per Mason J at 47.

<sup>10</sup> *Chapman* per Dixon CJ, Kitto, Taylor, Menzies and Windeyer JJ at 121, citation omitted.

<sup>11</sup> See Appendix A.

<sup>12</sup> See section 3.10.

<sup>13</sup> ‘Psychosis’ and ‘schizophrenia’ are defined in Appendix A.

#### 14.4 The burden of referral

Section 5B of the *CLA* refers to ‘the burden of taking precautions to avoid the risk of harm’.<sup>14</sup> The extent of the burden can, it is suggested, be assessed through reference to the expense, difficulty and inconvenience of taking the precaution in question.<sup>15</sup>

Referral would involve only minimal expense, difficulty or inconvenience for clergy. It need involve no more than the making of elementary telephone inquiries regarding contact details of general practitioners or mental health professionals prepared to examine or treat depressed persons, and providing those details to the client.

The cleric could provide brief explanation along the lines that such practitioners could assist with the diagnosis and management of depression. The cleric need not make the appointment with the other practitioner for the client.

Referring the client to another practitioner would involve *less* effort than continuing to counsel the client, although the pastoral counselling could continue if desired.

It is not suggested that clergy must seek to identify the best possible mental health professional. Nor is it argued that clergy have a duty to decide whether referral to a general practitioner would be more suitable than a mental health professional. Professor Parker recommended:

Different approaches and treatments suit different people so I am not going to stipulate that [a depressed person] must consult either a general practitioner, a psychiatrist, a psychologist or a counsellor - everyone has access to different resources and facilities.<sup>16</sup>

Counsel for the plaintiffs in *Nally* did not argue that the alleged duty to refer was a duty to have referred Nally to a specific type of professional:

[The defendants] had a duty to refer him to someone ... It could have been a psychiatrist, a psychologist, or even a pastoral counseling center.<sup>17</sup>

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<sup>14</sup> See section 13.1.

<sup>15</sup> This is consistent with the common law position - see section 13.1.

<sup>16</sup> Parker, 2002, 4.

<sup>17</sup> Argument to the Californian Supreme Court, paraphrased in Weitz, 175.

The only exception to this might be if the client was expressly indicating that they were seriously considering suicide. In the US it has been opined:

In the case of suicidal persons, to whom should the pastor make the primary referral? If a person is actively threatening suicide, the primary referral should be to a psychiatrist [or] hospital ... that is equipped to deal with such persons on a crisis basis ... If the situation is less than an emergency, the choice of referrals becomes more open.<sup>18</sup>

This raises the possibility of whether clergy must refer an expressly suicidal client to a general practitioner or non-psychiatrist mental health professional, as opposed to a psychiatrist. It is not argued that clergy must do so. If the client was referred to a general practitioner or mental health professional such a practitioner could decide whether a psychiatric referral was warranted. If the client did not attend, they would probably not attend a psychiatrist or hospital instead.

There is also the issue of whether, if referral is made but the client does not follow up the referral and the pastoral counselling continues, reasonable care would require a cleric to periodically suggest attendance of a general practitioner or mental health professional. It would not require much additional effort for the cleric to do so, which would favour such a requirement.

Although such periodic suggestions may be important in that a client may thereby benefit, the issue of whether clergy must do so is probably minor. If the client did not attend a general practitioner or mental health professional when first referred, it would be hard for the client to demonstrate, in the event of litigation, that he or she would have done so if subsequently referred.

Counsel for the plaintiffs in *Nally* suggested that reasonable care may have required the defendants to *persuade* a client to attend a mental health professional:

“Does this discharge the duty, by referring Ken to a doctor?” asked the court [the Californian Supreme Court]. Essentially yes, was Barker’s response. Except if Thomson or whoever was doing the referring knew that Ken would not go or would not cooperate, they had a duty to go further, perhaps even to persuade him to voluntarily admit himself.<sup>19</sup>

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<sup>18</sup> Sullender & Malony, 207.

<sup>19</sup> Argument to the Californian Supreme Court, paraphrased in Weitz, 175.

Whatever reasonable care may or may not have required in the particular facts of *Nally*, it is not argued that clergy must persuade a client to attend a general practitioner or mental health professional. Advising a client to do so, and that those practitioners may be able to assist with the diagnosis and management of depression, would suffice.

#### **14.5 Common sense supports referral**

Common sense is often useful in determining what constitutes reasonable care. Gaudron J stated:

Notwithstanding that [questions of negligence in diagnosis or treatment] arise in a medical context, they are often matters of simple commonsense. And, at least [sometimes] questions as to the reasonableness of ... precautionary measures are also matters of commonsense.<sup>20</sup>

Further, in the opinion of four members of the Court, common sense is ‘basic to the common law of negligence’.<sup>21</sup> While ‘not a substitute for legal analysis when that is required’, common sense ‘is important’.<sup>22</sup> There are reasons of common sense to think that clients would benefit from referral.

First, referral would assist with diagnosis. General practitioners have the capacity to perform or arrange physical examinations and blood tests which would assist in determining whether the problem is depression or some other condition with similar symptoms. They would also have the option of referring the client to a mental health professional.

If the referral was to a mental health professional, he or she would have the option of referring the client to a general practitioner for examination or tests. If the pastoral counselling continued, the cleric could ask the client what diagnosis had been made.

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<sup>20</sup> *Rogers* at 493.

<sup>21</sup> *Cook* per Mason, Wilson, Deane & Dawson JJ at 383.

<sup>22</sup> *Modbury* per Gleeson CJ at 167.

When attempting to solve a problem, such as depression, an obvious step is to try different potential solutions until one or more that works is found. There are a range of treatments for depression as seen in chapter three. There is evidence that ‘virtually all depressed clients will respond to some form of treatment’.<sup>23</sup>

Where practitioners offer only one type of treatment for depression and do not refer, therefore, this could mean that a client does not receive the opportunity to undergo other treatments of potentially greater benefit.

It is irrelevant that clergy, unlike mental hospitals or gaols, cannot take measures to physically prevent clients from attempting suicide. This is because the content of their duty, if one arises, is to take *reasonable* care, not measures they cannot take. There is no requirement that compliance with a proposed duty must *guarantee* the safety of the person to whom the duty is owed. As Kaufman J said in *Nally*:

A psychiatrist’s duty is to take reasonable steps to prevent a patient’s suicide. This does not imply, as the majority asserts, that a psychiatrist can guarantee his patient’s safety. On the contrary, as Justice Mosk [one of the majority judges] has observed “psychiatric predictions of violence are inherently unreliable”.<sup>24</sup>

## **14.6 Pastoral counselling experts support referral**

There is support for referral among pastoral counselling experts. Dr Paul Whetham lectures in counselling at the University of South Australia.<sup>25</sup> Dr Whetham agreed with the general proposition that different solutions will work for different people, and that where counselling for depression is provided, more than one approach should be considered.<sup>26</sup>

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<sup>23</sup>See Beutler, Clarkin & Bongar, 8, quoting the US Agency for Health Care Policy Research.

<sup>24</sup>253 Cal. Rptr. 97 (Cal. 1988), 117, note 8, citations omitted.

<sup>25</sup>Dr Whetham is the author of Whetham, P.J. 1997 *Understanding the Relationships of Clergymen Using Personal Construct Psychology*, Ph.D. Thesis, University of Wollongong. Sixty male clergy from Anglican, Baptist, Catholic, Pentecostal and Uniting churches completed a survey by Dr Whetham, who concluded *inter alia* that clergy suffer from high levels of uncertainty and are expected to do the impossible by their churches.

<sup>26</sup>Telephone conversation with the author 31.07.02.

Mr Ron Perry, Vice-President of the Psychotherapy and Counselling Federation of Australia and Director of the Institute of Counselling: Archdiocese of Sydney (sponsored by the Catholic Church), states that clergy should ‘not just keep going’ with the same methodology where the first approach has been ineffective, and that the less training clergy have had in diagnosis, the greater the need for prompt referral.<sup>27</sup>

The Rev. Keith Condie, who lectures in pastoral counselling at Moore Theological College in Sydney, said that to his knowledge many or most clergy do not provide ongoing counselling for depression, and that the main goal of clergy should be to encourage a depressed person to attend a general practitioner who may refer the client to a mental health professional.<sup>28</sup>

Further afield, the necessity for clergy to refer depressed clients is recognised in the US. Reference has been made to the ‘dangers’ of not doing so:

[A writer] summarised the following potential pitfalls and dangers of religious psychotherapy ... Applying only religious interventions to problems that may require medication or other medical or psychological treatment.<sup>29</sup>

The need to refer a client to a general practitioner or mental health professional would therefore seem to be well recognised among pastoral counselling experts.

#### **14.7 Secular experts support referral**

The *NHMRC Guidelines* state that ‘multiple treatment interventions ... will often be required for effective treatment [of depression]’,<sup>30</sup> that ‘more than one therapeutic technique ... could be useful’<sup>31</sup> and:

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<sup>27</sup> Mr Ron Perry, conversation with the author, 26.07.02.

<sup>28</sup> Conversation with the author 31.07.02.

<sup>29</sup> Tan, S.Y. ‘Integrating Spiritual Direction into Psychotherapy: Ethical Issues and Guidelines’ (2003) 31 *Journal of Psychology and Theology* 14, 16.

<sup>30</sup> *NHMRC Guidelines*, xv.

<sup>31</sup> *Ibid* 98.

A psychiatric referral is indicated if (i) the client is suicidal; (ii) the depression is severe; (iii) there are psychotic symptoms; (iv) there is a bipolar disorder or (v) treatments have been unsuccessful.<sup>32</sup>

This does not mean a duty to refer should be imposed where clergy provide pastoral counselling for depression, but it does support the proposition that referral of depressed clients by non-professionals to others more qualified may benefit clients.

#### **14.8 Church codes or rules support referral**

There is support among at least some church codes for the concept of referral. A handbook containing guidelines for pastoral ministry produced by a diocese of one church states:

Clergy have a responsibility to maintain high standards of knowledge in all areas of ministry appropriate to their position ... They shall recognise the boundaries of their professional competence ... and refer people as necessary to an appropriate professional or colleague.<sup>33</sup>

Another such publication from a different church states:

Out of desire for the well-being of those who come to them ... clergy recognise the limits of their own skills, and avoid giving advice or counselling in areas where they judge they are not competent to do so. Among the behavioural standards that might follow from this principle are: ... maintaining an awareness of the professionals to whom one can refer people with specific needs ... assessing the needs of a person who seeks assistance with any complex personal or relationship problem, and then referring the person on to an appropriately qualified professional ... Pastoral care ... means that a pastoral relationship would be terminated when it became reasonably clear that the person seeking support was not benefiting from it. In such a case the person would be offered help to find another source of assistance ... behavioural standards that might follow from this principle [include] developing and maintaining a referral network ...<sup>34</sup>

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<sup>32</sup> *Ibid* xv.

<sup>33</sup> Sherlock, C. (ed) 2001 *A Pastoral Handbook for Anglicans: Guidelines for Pastoral Ministry in the Anglican Diocese of Melbourne*, Acorn Press, 244.

<sup>34</sup> *Integrity in Ministry - A Document of Principles and Standards for Catholic Clergy and Religious in Australia* (1999), National Committee for Professional Standards, 1999, a committee of the Australian Catholic Bishops Conference and the Australian Conference of Leaders of Religious Institutes, 11-12. Publisher not indicated.

The fact that some church codes support referral is a relevant matter which to some extent favours imposition of the duty to refer, although it is not conclusive of the issue as discussed in the previous chapter.

#### **14.9 Referral has no significant disadvantage**

Several matters associated with referral may seem to detract from the utility of the duty to refer, however on examination none of them amount to sufficient reason not to refer.

First, a cleric may be concerned that a general practitioner or mental health professional to whom referral could be made might not be competent. If so, measures to establish such a practitioner's competency could be taken.<sup>35</sup>

Second, medical practitioners in New South Wales have the power to commit clients to a mental institution against their will.<sup>36</sup> This possibility may disturb some clients. A majority of the Californian Supreme Court stated in *Nally*:

A newly formulated standard of care that would impose a "duty to refer" ... on [personnel such as clergy] could deter those most in need of help from seeking treatment out of fear that their private disclosures could subject them to involuntary commitment to psychiatric facilities.<sup>37</sup>

This is not a convincing argument. Those 'most in need of help' need not only the help of clergy but also of a mental health professional or a general practitioner. Further, requiring clergy to refer a client by providing contact information for other practitioners to the client does not mean clergy must disclose information about the client to medical practitioners:

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<sup>35</sup> If a cleric ought to have reasonably have known that the practitioner to whom the client was referred was incompetent, liability for negligent referral could theoretically ensue, however, this would be extremely unlikely. See also Reichert, J. 'Negligent referral is a valid claim, court says' (June 1999) 35 *Trial* 91 regarding liability of general practitioners for negligent referral.

<sup>36</sup> A person may be detained in a hospital on the certificate of a medical practitioner or accredited person who has examined the person shortly before completing the certificate, believes the person is mentally ill or disordered and is satisfied such detention is necessary - *Mental Health Act 1990* (NSW) section 21. Section 23 provides that a medical superintendent at a hospital may detain a person on written request of a relative or friend of the person if the circumstances are urgent and a section 21 examination is not reasonably practicable.

<sup>37</sup> (1988) 253 Cal. Rptr. 97 at 109.

While it may be true that some people feel more comfortable and secure taking their problems to a cleric, and consequently a cleric may be able to get involved at an earlier stage than other professionals, a duty to refer should not change that.<sup>38</sup>

Third, some religious clients may view attendance of mental health professionals as indicative of inadequate faith in God,<sup>39</sup> and prefer to seek help from practitioners they know to be Christians.<sup>40</sup> That should not prevent a cleric from offering relevant contact information; it would be for the client to decide whether to use it.

Fourth, some clergy may feel uncomfortable in referring a client to a practitioner who may not be sympathetic to the cleric's or the client's religious beliefs. Once again it would be for the client to choose whether to attend an alternative practitioner. Clergy could obtain contact details for mental health professionals who are sympathetic.<sup>41</sup>

Fifth, it could be argued that referral may not be in a client's interest once pastoral counselling has commenced because the client might become confused if interventions for depression are constantly changed or may not be able to focus on more than one intervention simultaneously.

Clients need not be encouraged to use all treatments at once, however, and treatments once commenced need not be discarded as ineffective before the expiry of a trial period. Most clients would be capable of comprehending the rationale for trying different treatments if the first is ineffective.

#### **14.10 The social utility of pastoral counselling for depression**

Compliance with the duty to refer would not diminish the social utility of pastoral counselling for depression. The pastoral counselling could continue after referral if desired. Referral would enhance its social utility:

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<sup>38</sup> Burton, 513.

<sup>39</sup> Eg. King, R. 'Evangelical Christians and Professional Counseling: A Conflict of Values?' (1978) 6 *Journal of Psychology and Theology* 276, 277.

<sup>40</sup> See eg. Sullender & Malony, 204.

<sup>41</sup> Clergy could have a panel of reliable referral sources not only for suicidal persons but for other problems which might be contributing to the depression - cf. Sullender & Malony, 206.

The imposition of liability, far from exerting a chilling effect upon the clergy-congregant relationship, would enhance it by giving the congregant a greater sense of security in the clergyman's competence and sincerity.<sup>42</sup>

It has been similarly stated:

A sick patient who approaches his or her medical doctor does not lose confidence in the doctor when he or she refers the patient to a specialist who is better equipped to deal with the patient's specific medical problem. Similarly ... the parishioner will not likely lose confidence in the cleric who suggests that the counselee may be directed to a counselor more skilled ...<sup>43</sup>

The value of referral has also been recognised in the social work domain. Comparisons between clergy and social workers have been drawn by the Australian Law Reform Commission.<sup>44</sup> The referral practices of social workers, although not of direct relevance to clergy, are therefore noted in the next section.

#### **14.11 Social workers and referral**

According to the Australian Association of Social Workers ('AASW') 'all social workers must complete a minimum of four years tertiary education at one of the many universities that offer a social work degree', and 'some social workers act as information givers, providing enquirers with information about a large range of resources and services'.<sup>45</sup> The *Practice Standards for Social Workers* of the AASW state:

Firstly, knowledge from other disciplines is an essential component of social work education and continuing professional development ... Social work knowledge and skills ... necessarily include: ... skills in making assessments and deciding on the most appropriate intervention with which to respond to particular situations ... Where the social worker does not have the necessary knowledge, skills or resources to offer an appropriate and satisfactory service to the client, the client is advised and referred to another service or agency ...<sup>46</sup>

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<sup>42</sup>Bergman, 62.

<sup>43</sup>Taylor, T., 138.

<sup>44</sup>'The pastoral ministry undertaken by clerics is generally accounted as analogous often to that of the therapist or social worker' - *The Australian Law Reform Commission Report on privilege*, quoted in Fisher & MacFarlane, 278.

<sup>45</sup>[www.aasw.asn.au](http://www.aasw.asn.au). See *Becoming a Social Worker and The Social Worker's Role*.

<sup>46</sup>[www.aasw.asn.au](http://www.aasw.asn.au). See *Publications - Practice Standards*.

It appears therefore that social workers refer clients to those more able to assist them, however this does not mean that a cleric could be expected to do so when providing pastoral counselling for depression. The relevant inquiry is whether reasonable care in the circumstances of the particular case would warrant referral.

## **Conclusion**

The risk of a suicide attempt by a depressed client is not insignificant. Serious harm may result from a suicide attempt. Other forms of harm may also result from unnecessarily prolonged depression.<sup>47</sup>

Referral of the client to a general practitioner or mental health professional is not too expensive, difficult or inconvenient for clergy. Such a measure is supported by common sense, as discussed in this chapter. Common sense is 'basic to the common law of negligence'.<sup>48</sup> Referral does not appear to have any significant disadvantage.

Referral of depressed clients by clergy is also supported by pastoral experts. To some extent this favours imposition of the duty to refer, where a duty of care arises at all, but is not conclusive.

The fact that some church codes recommend referral by clergy of persons who they judge to require assistance beyond their competence to provide is a relevant matter which to some extent favours imposition of the duty to refer, although it is not conclusive.

The *NHMRC Guidelines* state that a psychiatric referral of a client is indicated if the depression is severe or bipolar, the client is suicidal or psychotic, or treatments have been unsuccessful. This does not mean a duty to refer should be imposed where clergy provide pastoral counselling for depression, but it does support the proposition that referral of depressed clients by non-professionals to others more qualified may benefit clients.

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<sup>47</sup> See Appendix A.

<sup>48</sup> *Cook* per Mason, Wilson, Deane & Dawson JJ at 383.

Although the *NHMRC Guidelines* makes reference to a ‘psychiatric referral’, it is not argued that clergy must refer severely depressed or suicidal clients to a psychiatrist as opposed to other types of mental health professional or a general practitioner. This is because it may not be reasonable to expect clergy to determine which clients require a psychiatrist as opposed to another mental health professional or general practitioner, and the various types of practitioner may each have something to offer the client in terms of assistance.

It is not possible to lay down a hard and fast rule that if a cleric provides pastoral counselling for depression and a duty of care arises the degree of care required will always include compliance with the duty to refer. Rather:

[S]cope of duty will always depend on the particular circumstances ...<sup>49</sup>

In other contexts the inappropriateness of universal rules regarding degree of care has been recognised, for example by Gleeson CJ:

Lord Macmillan observed in *Donoghue v Stevenson* that the law can only refer to the standards of the reasonable person to determine whether a duty of care exists. The same standards determine whether the duty has been broken. “The criterion of judgment must adjust and adapt itself to the changing circumstances of life.” [*Donoghue* per Lord MacMillan at 619] The capacity to adjust and adapt, which is inherent in the test of reasonableness, would be diminished if a more particular test were formulated. There is no reason to seek to do so. Whether it is reasonable to require an owner of the premises to have them inspected by an expert before letting depends on the circumstances of the case. There is no answer which is of universal application.<sup>50</sup>

Whether a cleric must refer a client will therefore depend on the facts of the particular case. When providing pastoral counselling for depression as defined herein a reasonable cleric, and a conclusion about what is reasonable is ultimately a matter of opinion, would generally comply with the duty to refer subject to exceptional circumstances, if a duty of care first arose.

Exceptional circumstances might include situations where the client had already consulted other practitioners about their depression or was firmly opposed to doing so.

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<sup>49</sup> *Astley* per Callinan J at 51.

<sup>50</sup> *Jones* per Gleeson CJ at 11.

Referral is not unduly difficult and costs nothing, or next to nothing. Referral would improve the chances of an accurate diagnosis of the client's condition, and of the client obtaining access to a range of potentially beneficial treatments. It does not require special training to recognise this. The pastoral counselling could continue if desired.

Focussing the client's attention on a religious remedy for depression without also referring the client may place the client at risk of unnecessarily prolonged depression and consequent loss or injury such as from a suicide attempt. The duty to refer is a minimal requirement, not an exacting one:

The minimal duty which ... can and should be imposed on the clergyman is to recognise his own limitations and to refer those cases which are beyond his competence to practitioners with more specialized training.<sup>51</sup>

### **Breach of the duty to refer - the point at which it may reasonably be imposed**

If a relevant case arose and breach of a duty to refer was alleged it would involve either an allegation of a total failure to refer the client or an allegation that referral occurred too late. In the former situation, specification of the precise point at which the duty to refer arose would not be required in order to determine whether a breach of duty occurred.

In the latter situation, this will depend on the circumstances of the particular case. It would be for a court to fashion the duty to refer into a precise rule applicable in a particular case. As Hayne J has said:

[T]o make a finding that there has, or has not, been a failure to meet a standard of reasonable care requires the tribunal (be it the judge or a jury) to translate the relevant legal principle ... into what Fleming described as "a concrete standard applicable to the particular case", and as a process which "involves not a determination of fact, but the formulation of a value judgment or norm".<sup>52</sup>

The thesis does not adjudicate on a particular case. Comments as to when it might be reasonable to impose the duty to refer must therefore to some extent be general.

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<sup>51</sup> Bergman, 66.

<sup>52</sup> Woods at 506.

The duty to refer will not arise unless the postulated duty of care arises. That duty of care will not arise unless pastoral counselling for depression is provided. The duty of care will arise in circumstances described in previous chapters.

The cleric should not wait to see whether the pastoral advice benefits the client, and should not wait until the client's depression is worsening or until the client becomes suicidal. This would at least partially defeat the purpose of imposing the duty to refer, which is to give the client a better opportunity to obtain an accurate diagnosis and to receive alternative treatments, or information about those treatments.

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In *Nally, Kaufman and Broussard JJ* appeared to view referral of the client to 'professional medical care' as the only measure which reasonable care might have required of the defendants:

In light of the ... factual background ... the defendants owed a duty of care to Nally. That duty, in my view, was simply to recognise the limits of their own competence to treat an individual, such as Nally, who exhibited suicidal tendencies, and once having recognised such symptoms, to advise that individual to seek competent professional medical care.<sup>53</sup>

In the next chapter it will be seen that while the duty to refer is the main constituent of the degree of care, it is not the only measure which reasonable care might require.

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<sup>53</sup>253 Cal. Rptr. 97 (Cal. 1988), 117.

## OTHER POSSIBLE FORMS OF CARE

### Introduction

The purpose of this chapter is to identify the approximate outer limits of what reasonable care might require of clergy, to aid the discussion of policy in the next chapter, in that regard can be had to the approximate burden that reasonable care may impose on clergy.

While degree of care is a significant issue in its own right, it is not intended to provide a definitive indication of the overall degree of care of clergy who provide pastoral counselling for depression. Space limitations preclude extended consideration of the ‘standards’ mentioned.

Indeed, precise specification of the overall degree of care in the abstract, in the absence of a concrete fact situation is undesirable, if not impossible, as the degree of care required depends to a considerable extent on the facts of the case. Members of the Court have cautioned against attempts to precisely specify the degree of care in advance of particular cases. Speaking of the degree of care of a firm of solicitors, Deane J indicated:

It is neither necessary nor desirable to attempt to define, in the abstract, the precise content of the firm’s duty of care or the precise extent to which the firm was required to take positive action.<sup>1</sup>

Similarly, Hayne J stated in a passage later approved by Gleeson CJ and Gummow<sup>2</sup>:

Because the extent of a duty falls for decision in relation to “concrete facts arising from real life activities” it will not always be useful to begin by examining the extent of a defendant’s duty of care separately from the facts which give rise to a claim. That may be possible, and useful, in a simple case (like motorist and injured road user) where the duty of care and its content is well-established. In other cases, however, it may lead to an insufficiently precise formulation of the duty which obscures the issues that require consideration.<sup>3</sup>

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<sup>1</sup>*Hawkins* at 580.

<sup>2</sup>*Tepko* per Gleeson CJ, Gummow & Hayne JJ at 777.

<sup>3</sup>*Modbury* at 182-183, citation omitted.

In Windeyer J's view it was not possible to precisely specify the degree of care expected of architects:

In some situations, the courts have not left the ... question [of degree of care] wholly at large. They have indicated what a reasonable man must do, or not do, to satisfy the duty of care that the situation of the parties has created. And what an architect must do to avoid liability for negligence cannot be more precisely defined than by saying that he must use reasonable care, skill and diligence in the performance of the work he undertakes.<sup>4</sup>

Consequently, while some comment in relation to degree of care is made in this chapter, it would be inappropriate for the thesis to essay a precise and definitive statement of the overall degree of care required of clergy who provide pastoral counselling for depression. Specification of the degree of care required of practitioners in the mental health field generally is a particularly imprecise art:

Few in the Court and legal system would question the fact that, at present, psychiatric treatment and diagnosis are imprecise arts ... there is little doubt that most mental health professionals contend with a considerable lack of consensus. Within the mental health fields, disagreements abound regarding appropriate theoretical models, problem etiologies, appropriate diagnostic criteria and terminologies, treatment indications, goals and modalities, curative factors in treatment, and assessment of treatment progress and outcome.<sup>5</sup>

Consideration of what it *might* be reasonable to expect clergy who provide pastoral counselling for depression can most conveniently start with identification of what may be useful to clients. Of course, the fact that a measure or precaution may be useful to a client does not mean that it is unreasonable for a cleric not to take or implement the measure or precaution.

Although the question of what is reasonable cannot be entirely supplanted by questions of what is scientifically proven or empirically supported, it is also necessary to consider the extent to which possible interventions for depression have been investigated and supported by evidence.

In first section, therefore, the main treatments for depression which have been identified by experts as supported by evidence will be considered.

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<sup>4</sup> *Voli* at 84-85.

<sup>5</sup> Beutler, Clarkin & Bongar, 10.

## 15.1 The main treatments for depression

Treatments for depression were set out in chapter three. For convenience some of that material is revisited.

The treatments for major depressive disorder listed in the *NHRMC Guidelines* as being of confirmed or probable efficacy are anti-depressant medication and cognitive behavioural therapy, though some anti-depressants are of possible efficacy only.<sup>6</sup>

Only practitioners with medical qualifications can provide anti-depressant medication.<sup>7</sup> Provision of cognitive behavioural therapy requires training in a mental health profession.<sup>8</sup>

The main treatments for bipolar disorder (or ‘manic depression’) are pharmacological.<sup>9</sup> Electro-convulsive therapy is also used in some cases.<sup>10</sup> ‘There is a paucity of literature concerning the psychological treatment of bipolar disorder’.<sup>11</sup>

There are therefore only a very limited number of interventions for depression identified by the *NHMRC Guidelines* as being of confirmed or probable efficacy. The *APA Guideline* takes a similar position to the *NHMRC Guidelines* in relation to major depressive disorder:

Cognitive behavioural therapy [has] ... the best-documented effectiveness in the literature for the specific treatment of major depressive disorder ... although some data suggest that cognitive behavioural therapy alone may be effective for patients with ... major depressive disorder, most such patients will require medication.<sup>12</sup>

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<sup>6</sup> See section 3.8.

<sup>7</sup> *NHMRC Guidelines*, 86.

<sup>8</sup> *Id.*

<sup>9</sup> See section 3.8.

<sup>10</sup> *Id.*

<sup>11</sup> *NHMRC Guidelines*, 85.

<sup>12</sup> *APA Guideline*, 11.

It is a legal impossibility for clergy to provide pharmacological treatments. Requiring clergy to implement cognitive behavioural therapy would be unreasonable when that would require training in a mental health profession.

It is unnecessary to consider whether every conceivable non-pharmacological measure, precaution or counselling technique (religious or otherwise) that might be of some benefit to a depressed client should be imposed on clergy as a legal obligation.

To expect clergy to be proficient in methodologies which the panels of experts who prepared the *NHMRC Guidelines* and the *APA Guideline* have not identified as being of either confirmed or possible efficacy in the treatment of depression would be, it is suggested, unreasonable.

## 15.2 No duty to diagnose

The management of depression begins with diagnosis.<sup>13</sup> Mental health professionals would generally owe a duty of care involving a requirement to ask questions of the client to reach a diagnosis. It has been asserted in the US:

There is an urgent need to train clergy in the recognition of depression and suicide risk factors ... the single most important ... factor in increasing the rate of appropriate referrals to mental health professionals is training in diagnostic skills.<sup>14</sup>

While it might be useful if clergy could recognise depression, it is not argued that clergy have a duty to recognise or diagnose depression. As already seen, clergy could not reasonably be expected to do so.<sup>15</sup> This is true even though some clergy receive a small amount of training in the diagnosis of depression.<sup>16</sup>

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<sup>13</sup>*NHMRC Guidelines*, 55.

<sup>14</sup>Weaver, A.J. 'Has There Been a Failure to Prepare and Support Parish-Based Clergy in Their Role as Frontline Community Mental Health Workers: A Review' (1995) 49 *Journal of Pastoral Care* 129, 135-136.

<sup>15</sup>See section 3.7.

<sup>16</sup>Clergy at Moore College in Sydney receive one lecture in this regard, for example - conversation by the author with Rev. Keith Condie, lecturer in pastoral counselling, Moore Theological College, 31.07.02.

### **15.3 Requirement not to discourage other treatment**

It was alleged in *Nally* that the defendants ‘actively and affirmatively dissuaded or discouraged [Nally] from seeking further professional psychological and/or psychiatric care’.<sup>17</sup> It is not suggested that many clergy in Australia discourage the attendance of such practitioners.

Reasonable care would require clergy not to discourage a client from attending general practitioners or mental health professionals in relation to depression, at any rate absent some indication that the client proposed to attend a practitioner who was known to be incompetent or unethical.

Reasonable care would also require the clergy not to discourage use of the main treatments for depression. Interfering with medical treatment has clear risks:

[I]nterference with the proper course of treatment of a serious condition may do irreparable damage. Instances are not unknown where a faith healer has removed splints or other appliances from patients suffering from tuberculosis of bones or joints - with disastrous results to life or limb.<sup>18</sup>

The above passage relates to ‘faith healers’ and physical ailments, however it illustrates the way in which discouragement of use of the main treatments for depression or attendance of general practitioners or mental health professionals could have adverse consequences for a client.

### **15.4 Warning not to discontinue other treatments**

It is submitted that a reasonable cleric could foresee that a client who commences pastoral counselling for depression may already be taking medication or attending a general practitioner or mental health professional for depression, and that the client could discontinue these measures on the basis of receipt of pastoral counselling for depression. It is arguable that reasonable care would require a cleric to warn the client not to do so.

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<sup>17</sup> 253 Cal. Rptr 97 (Cal. 1988), 102.

<sup>18</sup> Begg, A.C., O.B.E., 1932 *Faith Healing: Its Uses and Limitations* Longmans Green & Co. London, 36.

## **15.5 Referral of clients to practitioners who may be able to help with problems contributing to the depression**

A depressed client may have problems apart from depression. For example a client may have a drug or alcohol problem, a gambling problem, financial or legal problems, a physical medical condition, or family problems. In some cases those other problems may be contributing to the depression. Attempts to address these problems is not pastoral counselling for depression as defined herein.

If a client had other problems regarding which other practitioners could assist it might be useful to the clients if the cleric referred the client to such other practitioners. A church code of conduct states that clergy should maintain ‘an awareness of the professionals to whom one can refer people with specific needs’.<sup>19</sup>

It is not argued, however, that the postulated duty of care would require a cleric to make inquiries of the client to establish whether the client had other problems and were contributing to the depression, and then refer the client to practitioners who might be able to assist with these problems.

In providing pastoral counselling for depression the task undertaken by clergy is solving of the problem of the client’s depression, not helping the client with every aspect of their lives. Apart from any benefits of the pastoral counselling itself, the primary way in which clergy can assist a client in relation to the depression is by referring them to a general practitioner or mental health professional.

## **15.6 Religious remedies for depression**

Religious approaches to the management of depression are not mentioned in the *NHRMC Guidelines*. This does not mean such approaches are not useful. As already noted, religious approaches to managing depression may be useful to some clients, however there is limited research confirming the efficacy of these measures.<sup>20</sup>

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<sup>19</sup> *Integrity in Ministry*, 11.

<sup>20</sup> See section 3.9.

Altruism could be viewed as a religious concept, though not unique to religion. Seligman, a psychologist whose ideas regarding cognitive behavioural therapy are referred to in the *NHMRC Guidelines*,<sup>21</sup> suggested engagement in altruism as a measure which may assist regarding depression. Seligman stated that the benefits of altruism will ensue even if partly motivated by desire to improve one's own health,<sup>22</sup> and:

If you engage in activity in service of the commons long enough, it will gain meaning for you. You may find that you get depressed less easily, that you get sick less often, and that you feel better acting for the common good ... most important, an emptiness inside you, the meaninglessness that rampant individualism nurtures, will begin to fill.<sup>23</sup>

The possible psychological benefits of altruism, as well as of another religious concept, namely forgiveness, have been noted.<sup>24</sup> There has, however, been 'little research investigating either their effectiveness or the likelihood of therapists promoting them with their clients'.<sup>25</sup>

To impose as a legal duty on clergy a requirement to recommend or provide religious remedies for depression when such remedies have not been recognised in the *NHMRC Guidelines* or the *APA Guideline*, and when there is limited research investigating their effectiveness, would arguably be unreasonable.

## 15.7 Understanding of religion-related problems

It has been suggested that 'pastoral counseling should focus on ... religious issues or religious dimensions of other issues that cause the [client] difficulty'.<sup>26</sup> This may be useful. Examples of religion-related problems include 'the inability to feel forgiven [which takes the form of] scrupulosity or over-zealous self-examination, intense feelings of unworthiness' and 'the feeling that one has been abandoned by God'.<sup>27</sup>

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<sup>21</sup> *NHMRC Guidelines*, 70.

<sup>22</sup> Seligman, M.E.P. 1991 *Learned Optimism* Random House Australia, Sydney, 290.

<sup>23</sup> *Ibid* 289.

<sup>24</sup> Canale, J.R., White, R. & Kelly, K. 'The Use of Altruism and Forgiveness in Therapy' (1996) 35 *Journal of Religion and Health*, 225.

<sup>25</sup> *Ibid* 225.

<sup>26</sup> Sullender & Malony, 205.

<sup>27</sup> Sevensky, R.L. Religion, Psychology and Mental Health' (1984) 38 *American Journal of Psychotherapy* 73, 81.

While it may be useful for clergy to understand or address such issues, the case for imposing a legal obligation on clergy to do so is not compelling. For example it would appear extremely difficult or impossible to specify what measures a cleric should or should not take in addressing a client's feeling that they had been abandoned by God.

## 15.8 The suicidal client

A client may give express indications of being suicidal. If the client was referred to a general practitioner or mental health professional and the counselling then ceased, the postulated duty of care would accordingly cease, if it had arisen. The cleric may still have a legal obligation not to disclose confidential information:

It should also be noted that the duty, in terms of a professional person's duty of confidence, continues even after the professional relationship has come to an end.<sup>28</sup>

Any such duty is separate to the postulated duty of care, as discussed in section 5.19. If the pastoral counselling continued after referral, but with the client also in regular contact with the general practitioner or mental health professional, the degree of care required of the cleric may be tempered by that fact. The degree of care required is in any event likely to be minimal, as discussed generally in this chapter.

In cases where referral is made, but the client does not attend another practitioner and the cleric continues to provide pastoral counselling for depression, questions arise as to whether there is anything else that the cleric could reasonably be expected to do.

Reasonable care would not require clergy to make a detailed assessment of suicidality of a kind that might be undertaken by a mental health professional.<sup>29</sup>

In the US, it has been suggested that a cleric who continues to counsel a suicidal person who is not receiving other assistance should consult with or be supervised by a more qualified person:

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<sup>28</sup> Fisher & MacFarlane, 280.

<sup>29</sup> The *NHMRC Guidelines* (at 67-68) state that risk factors for suicide include drug/alcohol abuse, prior suicide attempt, depression, antisocial or aggressive behaviour, family history of suicidal behaviour, availability of firearms. Signs of potential suicide include having accidents, risky behaviour, discussion of death or morbid themes, and giving away possessions. Suicide risk can be further assessed by eliciting information as to frequency, intensity and cause of suicidal ideation; the proposed method and time of suicide; availability of the method; and whether anything is militating against suicide such as a source of support or something to look forward to in future.

[L]et's say for the sake of argument, that a pastor's church is in a rural area or ... where affordable mental health services are ... scarce. And let's further say that the suicidal person also resists being referred elsewhere, and, because of one or both of these factors, the person's pastor agrees to continue to be the primary caregiver ... a clergyperson who chooses to continue as the primary caregiver for a suicidal person should be in regular consultation or supervision with another clinically trained person.<sup>30</sup>

It is not clear what use such consultation or supervision would be to the client. Research has not revealed support for such a measure in other literature. The best thing for the cleric to do would be to suggest, at regular intervals, that the client attend a general practitioner or mental health professional.

The counselling of a suicidal client is not itself an emergency situation, but clergy may encounter clients who are not only suicidal but on the point of attempting suicide, which might be viewed as an emergency. A lower degree of care can reasonably be expected in an emergency than when there is time for reflection and planning, and defendants will only be required to exercise the degree of care reasonable in the circumstances of the emergency.<sup>31</sup> This does not mean a duty of care could never arise in an emergencies.<sup>32</sup>

## 15.9 Basic information about treatments for depression

The *National Health and Medical Research Council Clinical Practice Guidelines: Depression in Young People: A Guide for General Practitioners* ('*NHMRC Guidelines for GPs*')<sup>33</sup> recommend that general practitioners should:

Establish positive expectancies. Explain that depression is common and that it can be treated successfully ... Provide information about depression ... how it can be treated ... Describe cognitive behavioural therapy and how it can help to reduce depression by increasing positive experiences, by teaching people to solve life problems, and by teaching people how to think about events in different ways.<sup>34</sup>

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<sup>30</sup>Sullender & Malony, 207-208. An article by Saccuzzo, D.P. 'Liability for Failure to Supervise Adequately Mental Health Assistants, Unlicensed Practitioners and Students' 34 *California Western Law Review* 115 (1997) is of interest in this context although it does not mention churches or clergy.

<sup>31</sup>Trindade & Cane, 458.

<sup>32</sup>*Ibid* 435.

<sup>33</sup>This publication is primarily a summary of the *NHMRC Guidelines*, but includes some material not in the main document.

<sup>34</sup>*NHMRC Guidelines for GPs*, 22-23.

It might be wondered whether reasonable care could ever require clergy who provide pastoral counselling for depression to provide basic information about cognitive behavioural therapy to a client, or for that matter anti-depressant medication or other pharmacological treatments.

The question is not whether the degree of care that can be expected of clergy is the same as or different to that of a psychologist or a general practitioner. The question is simply one of what reasonable care may require of clergy.

It could be argued that a reasonable cleric who provided counselling for depression would find out what experts have said about the treatment of depression, regardless of whether the counselling was ‘pastoral’. In this regard clergy could read the *NHMRC Guidelines*, which were not only designed for health professionals:

Although not specifically designed for non-health sector workers, the current guidelines may serve as a useful resource for school counsellors, teachers, youth workers and others ...<sup>35</sup>

On the other hand, whether brief research would enable clergy to properly explain cognitive behavioural therapy and pharmacological treatments is questionable. Therefore it could be argued that the case for requiring clergy to provide such explanation is not compelling.

### **15.10 Avoidance of counselling which exacerbates depression**

It is conceivable, as seen in section 10.2, that some pastoral counselling for depression may be harmful to a client, whether or not it diverts or delays a client from using the main treatments for depression.

As noted in that section, not every intervention for depression that could foreseeably be harmful will constitute a breach of duty. Thus even if a cleric says something in the course of pastoral counselling for depression that could foreseeably contribute to the client’s depression, this will not necessarily constitute a breach of duty.

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<sup>35</sup>*NHMRC Guidelines*, 7.

It is thus difficult to specify in advance of any relevant cases the forms of pastoral counselling which could potentially constitute a failure to exercise reasonable care. 'The line of distinction ... is not in any particular case easily drawn ... where a boundary must be identified between what is reasonable and what is not.'<sup>36</sup>

This is particularly so when there has been limited consideration of these issues in journals including the *Journal of Psychology and Theology*, the *Journal of Religion and Health*, the *Journal of Psychology and Christianity*, *Pastoral Psychology* and the *Journal of Pastoral Care*.<sup>37</sup>

In section 10.2 it was seen that sin-oriented counselling might exacerbate a client's depression. Other examples of counselling with the potential to be harmful include destructive criticism of the client, or a suggestion that misfortunes experienced by the client constituted punishment from God.

The latter situation appears to have occurred in *Nally*. Three weeks before his death Nally made a non-fatal suicide attempt by overdosing on an anti-depressant prescribed by a doctor. While he was unconscious he suffered an injury to his right arm:

Dr Evelyn ... believed Ken was recovering well physically and explained that the paralysis he felt in his right arm was only temporary. Often referred to as "Saturday Night Palsy", the condition was common among alcoholic patients who fall asleep in their chairs, cutting off the blood supply to their arm. Such a loss of blood apparently occurred when Ken overdosed.<sup>38</sup>

Nally's arm did not recover immediately, which distressed him. The defendants apparently told him that the disability to his arm was 'God's punishment':

Ken ... went to his car. His father followed him, pleading to know why he was so distraught. As Ken backed out of the driveway Walter Nally kept pace with the slow moving vehicle, all the while begging to know why Ken was so upset. Ken finally blurted out, "It's my arm, see how it is?" "What about it?" Walter asked, still walking to keep pace with Ken's car. "They [the defendants or some of them] told me it was because of my sin. They told me it was God's punishment, Dad!" Walter Nally could not believe his ears ...<sup>39</sup>

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<sup>36</sup> *Tame* per Hayne J at 411.

<sup>37</sup> This comment is based on inspection of hundreds of issues of those journals, and perusal of many articles within them.

<sup>38</sup> Weitz, 27.

<sup>39</sup> *Ibid* 28-29.

This example underlines the need for consideration of whether pastoral counselling may exacerbate a client's depression, however difficult it may sometimes be to draw the boundary between what is reasonable and what is not.

### **15.11 Avoid sudden termination of counselling**

Reasonable care would not require clergy to continue a counselling relationship indefinitely, however it may require clergy not to end the counselling relationship in an abrupt fashion or in a way that would signify rejection of the client. The notice which might be required would vary with the circumstances.

It may assist clients if clergy raise at the conclusion of counselling, as well as at an earlier stage, the issue of referral to a general practitioner or mental health professional, if the client was not already attending such a practitioner. That would be preferable to merely terminating the counselling without directing the client to alternative assistance:

[Counsel for the plaintiff] took Rea through every element of suicidal ideation. Rea admitted he knew and recognised each element and then conceded he had seen each element in Ken. Still he had not referred him to anyone else even after he refused to continue seeing him on a formal basis in 1978.<sup>40</sup>

### **15.12 Appropriate records**

One church code of conduct states:

Keeping appropriate records is an aspect of pastoral care. Among the behavioural standards that might follow from this principle are ... making a confidential note of any events in the course of a pastoral relationship that provoke concern in the minister. Such a note might include a record of the date, time and matter of concern.<sup>41</sup>

While this is not conclusive of whether reasonable care would require clergy to should keep confidential and securely stored records regarding pastoral counselling for depression, it could be argued that they should do so. It is unlikely that a failure to make a record of the counselling would in itself lead to damage to the client.

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<sup>40</sup>Weitz, 115.

<sup>41</sup>*Integrity in Ministry*, 12-13.

## Conclusion

The purpose of this chapter was to identify the approximate outer limits of what reasonable care might require of clergy, primarily to aid the discussion of policy in the next chapter, in that regard can be had to the approximate burden that reasonable care may impose on clergy.

While degree of care is a significant issue in its own right, the comments in this chapter are not intended to be a definitive indication of the overall degree of care of clergy who provide pastoral counselling for depression. Space limitations preclude extended consideration of the forms of care mentioned in this chapter.

Indeed, precise specification of the overall degree of care in the abstract, in the absence of a concrete fact situation is undesirable, if not impossible, as the degree of care required depends to a considerable extent on the facts of the case. Members of the Court have cautioned against attempts to precisely specify the degree of care in advance of particular cases.

Specification of the measures which reasonable care might require of a cleric who provides pastoral counselling for depression involves judgment and therefore opinion: 'judgment lies in the realm of values and what you choose depends on what you want'.<sup>42</sup>

The main constituent of the degree of care of clergy who provide pastoral counselling for depression is referral of the client to a general practitioner or mental health professional, absent special circumstances, such as if the client was already in regular contact with such a practitioner or was firmly opposed to attending such a practitioner.

Reasonable care would require the cleric not to discourage the client from seeking assistance or treatments for depression from a general practitioner or mental health professional, and to warn the client not to discontinue medication taken for depression, or attendance of a general practitioner or mental health professional, on the basis that the client is receiving pastoral counselling for depression.

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<sup>42</sup>Fleming, 234, citation omitted.

It may also be that reasonable care would require clergy to refrain from counselling which might exacerbate a client's depression, however it is important to note that even if a form of counselling might foreseeably exacerbate a client's depression, it would not necessarily constitute a breach of duty. Reasonable care does not require perfection.

Counselling which might be unreasonable in this regard would include that involving destructive criticism of the client, suggesting to the client that misfortunes experienced by the client constitute punishment from God, and possibly sin-oriented counselling.

'The line of distinction ... is not in any particular case easily drawn ... where a boundary must be identified between what is reasonable and what is not.'<sup>43</sup> The example of *Nally*, where the defendants allegedly told Nally that an injury he sustained in a non-fatal suicide attempt was a punishment from God underlines the need for consideration of whether pastoral counselling may exacerbate a client's depression, however difficult it may often be to draw the boundary between reasonable and unreasonable counselling.

It could also be argued that clergy should not terminate pastoral counselling for depression unnecessarily abruptly or in a way that would signify rejection of the client.

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Now that the degree of care which might be required of clergy has been considered, discussion of policy in the next chapter can occur in a more informed manner, in that regard can be had to the approximate burden which reasonable care might impose on clergy. As will be noted in the next chapter, the burden that a duty of care may impose on a class of potential defendants is not limited to the burden of taking precautions which reasonable care may require.

The thesis does not argue that policy reasons support the imposition of the postulated duty of care. Rather, the thesis argues that there are no compelling policy reasons to conclude that it should not be imposed.

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<sup>43</sup>*Tame* per Hayne J at 411.

## Chapter 16

### POLICY

#### Introduction

This chapter argues that there are no compelling policy reasons to reject the possibility of clergy being subject to a duty of care for pastoral counselling for depression.

The precise significance of policy has not been definitively determined by the Court. It is contended that in the context of pastoral counselling for depression, discussion of policy should focus on two main issues.

The first is whether it would be unreasonable, having regard to the public interest, for the cleric to be subject to a duty of care, in the circumstances of the case and in other cases of like circumstances.<sup>1</sup>

The second is whether imposing a duty of care in the circumstances of the case and other cases of like circumstances, would subject clergy to an unreasonable burden.<sup>2</sup> In determining whether a duty of care would impose an unreasonable burden on clergy it is relevant to consider not only the burden of taking the precautions which reasonable care may require, but also any other burden involved, for example the cost of obtaining insurance.

It is not argued that the postulated duty of care should be imposed because that would be in the public interest, or because it would impose a reasonable burden on clergy.

Rather, it will arise, if at all, from the relationship between the cleric and client. As Barwick CJ stated: ‘no doubt considerations of public policy have their place ... but basically it is the relationship of the parties which gives rise to ... a duty [of care]’.<sup>3</sup>

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<sup>1</sup> *Esanda* per McHugh J at 282: ‘the public interest argument is an important factor to be weighed [in considering a duty of care].’

<sup>2</sup> Cf. *Caltex* per Mason J at 591: ‘The law of negligence must balance against the interest of the injured party in recovering compensation the interest of the wrongdoer in avoiding subjection to a liability disproportionate to his negligent conduct’; *Modbury* per Kirby J at 179: ‘does the imposition of liability in a case such as the present on a party such as [the defendant] impose an unreasonable burden on it?’.

<sup>3</sup> *Smith*, 400.

Immunities from liability must satisfy ‘a heavy burden of justification’, as ‘favouritism and inequality of treatment under the law are capable of breeding contempt for the law’.<sup>4</sup> ‘Absolute immunity is in principle inconsistent with the rule of law but in a few, strictly limited, categories of cases it has to be granted for practical reasons’.<sup>5</sup> It is argued in this chapter that there is no compelling justification to grant clergy immunity from a duty of care in all cases involving pastoral counselling for depression.

## 16.1 The social problem caused by depression

Personal injury to individuals (such as might be caused by a suicide attempt) ‘ordinarily involves a net loss to social wealth’.<sup>6</sup> Depression is implicated in many suicides.<sup>7</sup> In New South Wales more than 700 people die from suicide each year, and for each person who dies from suicide there are another 30 - 40 people who attempt suicide.<sup>8</sup> Further:

Depression can lead to serious short and long-term problems including severe psychological distress ... and poor academic and work performance. In addition, depression is ... implicated in many cases of ... suicide. Depressive symptoms can also be the prodrome of ... a schizophrenic episode.<sup>9</sup>

The rate of depressed people committing suicide will be much higher than the rate of suicide in the general population: in the US it is estimated to be fifty times higher.<sup>10</sup> Thus the rate of clients committing suicide will also be much higher than the general population, unless counselling provided reduces that risk. As noted in the next section, the extent to which pastoral counselling for depression may do so is unclear.

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<sup>4</sup> *Giannarelli* per Wilson J at 575.

<sup>5</sup> *Darker v Chief Constable of the West Midlands Police* [2000] 4 All ER 193 per Lord Cooke of Thorndon at 202 quoted approvingly by Gaudron, McHugh & Gummow JJ in *Brodie* at 1012.

<sup>6</sup> *Perre* per McHugh J at 209.

<sup>7</sup> *NHMRC Guidelines*, 1; Oquendo, M.A. *et al* ‘Inadequacy of Antidepressant Treatment for Patients With Major Depression Who Are at Risk for Suicidal Behaviour’ (1999) 156 *American Journal of Psychiatry* 190, 190: ‘more than 50% of suicides occur in the context of an episode of major depression’.

<sup>8</sup> Nirui & Chenoweth, 361.

<sup>9</sup> *NHMRC Guidelines*, 1.

<sup>10</sup> Beutler, Clarkin & Bongar, 303.

## 16.2 The social utility of pastoral counselling for depression

If pastoral counselling for depression by clergy has social utility, that does not constitute a reason not to impose a duty of care - the work of medical practitioners is of social utility but they are subject to negligence law. This suggests that the social utility of a service will only tell against imposition of duty if there is evidence that imposing a duty of care will lead to withdrawal of the service.<sup>11</sup>

It is possible that pastoral counselling for depression by clergy may be beneficial in many instances.<sup>12</sup> Whether it is of overall social utility is a separate issue, and is considered in this section.

A US commentator noted that clergy have some advantages over mental health professionals because they are well known to parishioners, and in turn know parishioners; there is less stigma in consulting clergy than in consulting mental health professionals, therefore some people may be more likely to consult them at an earlier stage, creating opportunity for intervention before more serious problems develop.<sup>13</sup>

Counselling by clergy which is provided free of charge will be more accessible than that provided by mental health professionals, where the cost of the latter is not fully covered by the health system. Medicare does not cover consultations with psychologists or other counsellors apart from psychiatrists.<sup>14</sup>

The precise scheduled fee for a psychiatric consultation varies, depending on the type of consultation. \$130.00 is an approximate minimum figure, of which 85% is covered by medicare.<sup>15</sup> Presumably some psychiatrists charge above the scheduled fee.

Christian clients may view attendance of mental health professionals as indicative of inadequate faith in God,<sup>16</sup> and instead seek counselling from Christian clergy. Such clients may be reluctant to consult a mental health professional.

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<sup>11</sup>This issue is considered in section 16.4.

<sup>12</sup>Section 3.9.

<sup>13</sup>See eg. Klee, 220-221.

<sup>14</sup>Telephone conversation by the author with a Health Insurance Commission representative, 11.07.02.

<sup>15</sup>*Id.*

<sup>16</sup>Eg. King, R. 'Evangelical Christians and Professional Counseling: A Conflict of Values?' (1978) 6 *Journal of Psychology and Theology* 276, 277.

The use of antidepressants has had little effect on suicide rates, and studies have shown that between 9% and 33% of suicide victims were receiving antidepressants at the time of death.<sup>17</sup> A newspaper article reported:

Mental health groups and the family of [a suicide victim] remained sceptical ... about how much would be done to fix what they said was a dysfunctional and inadequate mental health system. The National Association of Psychiatrists said the separation of mental health and drug and alcohol services was a growing problem.<sup>18</sup>

Nirui & Chenoweth conducted a survey of fifteen relatives and friends of fifteen suicide victims. A lack of appropriate hospital management of suicidal people was raised by most of those surveyed.<sup>19</sup> Nirui and Chenoweth also identified areas of concern in relation to the management of depression by general practitioners:

General medical practitioners' lack of interest and/or experience in dealing with people who present with suicide ideation and depression and their over prescription of medications for suicidal symptoms are areas of concern.<sup>20</sup>

There is a lack of Australian empirical data concerning outcomes where clergy provide counselling for depression. Court states that 'it is impossible to determine the balance of good and harm which occurs' where clergy provide counselling.<sup>21</sup>

Professional standards officers and other representatives of Christian denominations in Sydney generally report an absence of either complaints or claims regarding counselling by clergy.<sup>22</sup> Rather than complain to the cleric's superiors about counselling which caused dissatisfaction, clients may be more likely to simply discontinue the counselling.<sup>23</sup>

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<sup>17</sup> Oquendo *et al*, 190.

<sup>18</sup> Robinson, M. 'Deaths in hospitals prompt call for inquiry' *Sydney Morning Herald* 31 July 2002:7.

<sup>19</sup> For example in one case a hospital psychiatrist spent only half an hour with a suicidal person following an overdose of tablets - Nirui & Chenoweth, 366.

<sup>20</sup> *Ibid* 362.

<sup>21</sup> Court, 143.

<sup>22</sup> Conversations by the author with Mr Philip Gerber (Anglican) 18.05.01; Rev Noel Edwards 11.07.02 (Baptist); Mr John Davoren 20.08.01 (Catholic); Fr. Brian Lucas 10.10.01 (Catholic); Ms Susan Hill 03.08.01 (Churches of Christ); Rev. Steve Shooter 03.08.01 (Congregational); Mr Bryce Dalgety-Bridges 03.08.01 (Uniting); Rev. Dr. David Millikan 24.08.01 (Uniting).

<sup>23</sup> Pastor Max Hogg, Manager, Child and Family Services, Presbyterian Church, conversation with the author 11.07.02.

A legal representative of one denomination advised that he believed an interstate cleric of that denomination had been the subject of a complaint regarding comments which might have been interpreted as encouragement of suicide.<sup>24</sup>

A Sydney solicitor is aware of the suicide of a man counselled by a cleric in the Sydney area.<sup>25</sup> The man had told the cleric he was suicidal. The cleric was later removed from his position, for a reason unknown to the solicitor; the reason may or may not have been connected to the suicide.<sup>26</sup>

The apparent absence of claims against clergy for negligent counselling does not mean no damage is caused. Publicly visible litigation and problems often represent the tip of an iceberg. Most clients will be unaware of negligence, particularly where it consists of an omission.

Even where counselling does not exacerbate a client's depression, they may be diverted or delayed from the main treatments for depression and thus deprived of the opportunity of improving. This latter fact should not be seen merely as a trigger for discussion of causation, but rather as highlighting the necessity for reasonable care to be exercised.

Should a client commit suicide, no one else may be aware of the content of the counselling or that counselling was being received. Even where a client or surviving family member recognises negligence, they may not sue because of reluctance to become involved in litigation or absence of desire for financial compensation.

### **16.3 The effect on client welfare of the possibility of clergy being subject to a duty of care**

There is no reason to impose legal standards if the interests of individuals and society is not thereby achieved, or if the goal can be achieved in another way. It has been argued in the US that a voluntary code of practice obviates the necessity for legal standards.<sup>27</sup>

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<sup>24</sup> Mr Bryce Dalgety-Bridges, conversation with the author 03.08.01.

<sup>25</sup> Telephone communication with the author 09.06.02, name of solicitor withheld by request.

<sup>26</sup> *Id.*

<sup>27</sup> Eg. McCaffery, 165.

This is unconvincing. All vocational groups can create their own standards, and many do, but that does not free those groups from their legal obligations. Moreover standards will not always be met. Their mere existence will not assist clients when they are breached. Thus voluntary codes will be less effective than legal standards.

On the other hand, a well-publicised claim, whether successful or not, may significantly alter the behaviour of clergy. In the US it has been stated:

One successful lawsuit that is well publicised may powerfully alter the behaviour of doctors. Those who are sued for failing to meet prevailing standards will supposedly improve their future standards of practice. Other physicians will be deterred from negligent practice by observing the plight of the ... defendant.<sup>28</sup>

Creation of and compliance with legal standards will not guarantee client welfare. This is not irrelevant: the effectiveness of compliance with the duty in preventing harm is arguably relevant to the reasonableness of the burden imposed.

The fact that a precaution will not ensure client welfare does not mean there can be no duty to take it, however. The law of negligence is predicated on the proposition that failure to take measures which may not eliminate all risk may still be negligent: it is axiomatic that doctors are not negligent merely because they fail to cure their patients or clients.<sup>29</sup> Doctors cannot always prevent or control cancer, but that does not relieve them of an obligation to hinder it.

Merely referring a client to a mental health professional does not mean the client will obtain beneficial treatment.<sup>30</sup> However many clients will follow up a referral made by clergy, and most depressed people respond to some form of treatment.<sup>31</sup> Therefore referral of the client will increase the probability of the client receiving effective treatment, and hence decrease the risk that their depression will worsen or not improve.

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<sup>28</sup> Halleck, S. 'Malpractice in Psychiatry' (1983) 6 *Psychiatric Clinics of North America* 567, 568.

<sup>29</sup> See eg. Partlett, 177.

<sup>30</sup> Whether a client would have followed advice if it was given is also relevant to whether failure to give the advice caused any damage. This is discussed in the next chapter which deals with causation.

<sup>31</sup> Beutler, Clarkin & Bongar, 8.

It is also necessary to consider whether imposing a duty of care would reduce *demand* for counselling from clergy.<sup>32</sup> Imposing standards could theoretically reduce demand because higher insurance premiums may ensue, leading clergy to charge a fee, thus reducing demand. Additionally, fear of liability may cause clergy to become more legalistic or cautious in their counselling, which may not be desired by clients.

#### **16.4 The effect on pastoral counselling of the possibility of clergy being subject to a duty of care**

It has been asserted in the US in relation to pastoral counselling that ‘one case that ends tragically could lose the good ... done for hundreds of thousands of others’.<sup>33</sup> The authors of an Australian text book stated: ‘individual plaintiffs may be required to submit to a risk for the sake of some greater good’.<sup>34</sup> This type of reasoning seemed to find favour with the Court in *Agar*, where it was said by four members of the Court that to impose a duty of care:

[W]ould deter those who fulfil the kind of role played by the [International Rugby Football Board] and the appellants in regulating that pastime from continuing to do so lest they be held liable ... The choices available to all would thus be diminished.<sup>35</sup>

Thus the Court may take account of the need to maintain choice in a case, should one arise, regarding pastoral counselling for depression by a cleric. This does not mean that unsafe activities should be equated with enhanced choice. On the contrary, danger will often deter participation, thus reining in practices of questionable safety may increase, not decrease, choice.<sup>36</sup>

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<sup>32</sup> Cf. *Esanda* per McHugh J at 283: ‘Extending the liability of auditors for negligent misstatements may also reduce the demand for their services. Even when insurance is obtainable, increasing fees to pay for the cost of additional insurance may result in a reduction of demand for audit services ...’.

<sup>33</sup> Hubbard, D., president of Fuller Theological Seminary, Pasadena, quoted by Worthington, R. ‘Suit Over Suicide Worries Clergy’ *Chicago Tribune*, 29 April 1985: 4.

<sup>34</sup> *Trindade & Cane*, 442-443.

<sup>35</sup> *Agar* per Gaudron, McHugh, Gummow & Hayne JJ at 583-584.

<sup>36</sup> Some members of the Court in *Agar* asserted that the danger of rugby union is part of its attractiveness - see Gleeson CJ at 561, Callinan J at 600-601. Even if this is true, clergy will not attract clients by being negligent.

Concern about reduced availability of choices has some validity in the context of pastoral counselling for depression. Despite the fact that the degree of care required of clergy involves little more than the duty to refer and does not require great competence for compliance, some clergy may not provide such counselling due to fear of litigation.

Clearly, if the possibility of reduction in services is relevant to duty issues then empirical research is required to determine the extent to which clergy are influenced by litigation fears. Of course, such fears are not the only factor likely to deter clergy from providing counselling for depression. Many will not wish to do so due to time constraints, lack of training or personal preference. Thus if services are withdrawn, it is necessary to consider precisely which services, by whom they are withdrawn, and why.

It is also necessary to consider the possibility that strict non-liability for clergy who provide counselling for depression would *discourage* members of the public from seeking or listening to their counsel, and the extent to which imposing a duty of care would benefit clients.

Most clergy are probably already aware of the *possibility* of being sued for negligent advice.<sup>37</sup> Hence it may be that many clergy likely to cease counselling due to fear of litigation have already done so. Were a court to decline to impose duties in one case this may not encourage these clergy to again provide counselling.

As seen above in this section, in *Agar* it was asserted that imposing duty on rugby administrators to make rugby scrums safer would deter people from being administrators to such an extent that the sport would be destroyed.<sup>38</sup> Yet as has been pointed out, the decision in *Rootes* to hold the driver of a boat towing a water-skier liable for injuries to the skier did not result in people withdrawing from sporting participation.<sup>39</sup>

While the consequences, or lack of consequences, of the decision in *Rootes* has no direct bearing on the effect of imposing a duty of care on clergy, it does illustrate that it should not be automatically assumed that imposing a duty of care on a class of potential defendants will lead to withdrawal *en masse* from an activity.

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<sup>37</sup> Clergy are commonly insured for 'counselling' and can hardly have failed to notice the problems experienced by other professionals in the wake of the HIH collapse.

<sup>38</sup> *Agar* per Gaudron, McHugh, Gummow & Hayne JJ at 583.

<sup>39</sup> Kirk, J. & Trichardt, A. 'Sports, Policy and Liability of Sporting Administrators' (2001) 75 *ALJ* 504, 523.

Hyperbolic rhetoric of potential defendants should not be uncritically accepted. It has been said that arguments about defensive practice are difficult to assess, as they usually consist of little more than assertion.<sup>40</sup> A call for a more robust attitude towards the threat of litigation has been made.<sup>41</sup>

## 16.5 The effect on case loads of courts of the possibility of a duty of care

In relation to the liability of auditors, McHugh J stated: ‘no examination of the public interest should overlook the effect of an extension of ... liability on the administration of the court system’.<sup>42</sup>

There is no reason why this would not apply equally to the liability of clergy. However this factor should not be given undue weight - if meritorious claims are brought that would not be a bad thing. A potentially large number of claims does not in itself tell against duty. ‘Courts do not hesitate to find a duty of care where an accident has caused extensive property damage or injury to many people.’<sup>43</sup>

A flood of claims seems unlikely.<sup>44</sup> Floodgates arguments usually illustrate a paucity of reason,<sup>45</sup> ‘do not help’,<sup>46</sup> and must ‘be taken with a grain of salt’.<sup>47</sup> In any event doctors do not cease to diagnose illness because hospitals are crowded, and judges should not reject meritorious claims because the courts are busy.

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<sup>40</sup> Jones, M. Editorial, (1996) 12 *Professional Negligence* 69.

<sup>41</sup> *Ibid* 70.

<sup>42</sup> *Esanda* at 283.

<sup>43</sup> *Perre* per McHugh J at 221.

<sup>44</sup> See section 16.8.

<sup>45</sup> Mullany, N.J. & Handford, P.R. 1993 *Tort Liability for Psychiatric Damage* The Law Book Company Ltd, Sydney, 18.

<sup>46</sup> *Perre* per Hayne J at 302: ‘References to the possibility that there are many persons in the same position as a particular plaintiff, or that losses sustained by a plaintiff and others in like cases are very large, do not help any more than do references to floodgates and the like’.

<sup>47</sup> *Hyde v Agar* (1998) 45 NSWLR 487, 513.

## 16.6 Telephone ‘counselling’ services

In *Nally* concerns were raised that the liability of clergy for counselling would lead to withdrawal of services by hotlines offering short-term ‘band aid’ assistance.<sup>48</sup> The potential liability of personnel staffing telephone ‘counselling’ services, religious or otherwise, regarding depression or suicide, or other serious issues, is beyond the scope the thesis. By way of background there are a number of such services in New South Wales and Australia.<sup>49</sup>

The potential liability of clergy for pastoral counselling for depression has no bearing on whether the personnel who provide those services owe a duty of care. Whether they do so or not depends on the application of the common law of negligence to the circumstances of those cases and any applicable legislation, not on whether pastoral counselling for depression by clergy attracts a duty of care.

## 16.7 The burden to churches of the possibility of clergy being subject to a duty of care

It is possible that a church may be liable for a want of care by cleric when providing pastoral counselling for depression.<sup>50</sup> The financial implications for churches of holding clergy liable for negligent counselling should be considered. Financial resources of churches will obviously vary from church to church. Smaller or single-congregation churches will probably in general have less resources than larger churches, thus claims for negligent counselling could have greater impact on those churches.

The burden of potential liability also depends on the cost and availability of insurance. Toohey and Gummow JJ expressed the view that ‘the Court is ... entitled to know that difficulties exist in obtaining insurance against such liabilities and that those difficulties are influenced by the state of the law’.<sup>51</sup> Mason J also adverted to the possibility of a defendant obtaining insurance, stating ‘an authority can, if it wishes, obtain protection against liability by means of insurance’.<sup>52</sup>

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<sup>48</sup> See eg. 240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987) 226; 253 Cal. Rptr. 97 (Cal. 1988), 109.

<sup>49</sup> Eg. Boystown Family Care Kids Helpline; Salvo Crisis Line: Suicide; Lifeline; Family Drug Support.

<sup>50</sup> The law and main issues relevant to the possible liability of churches are identified in chapter eighteen.

<sup>51</sup> *Romeo* at 447.

<sup>52</sup> *Shaddock* at 252.

Representatives of Christian denominations in Sydney do not report undue difficulty in insuring clergy for provision of counselling.<sup>53</sup> In fact some churches have their own insurance branch.<sup>54</sup> Insurance costs may increase in the event of a successful claim. Where insurance is available, this would also reduce the burden which a duty of care on would impose on clergy, which is discussed in the next section.

## 16.8 The burden to clergy of a duty of care

Adverse verdicts or settlement of claims would clearly be financially burdensome to clergy without insurance. Defence of claims in court would burden clergy, and distract them from other activities. Should it reach the trial stage, a claim for negligent counselling would probably receive considerable publicity, and the facts might not be reported correctly.<sup>55</sup>

The burden of potential liability depends on the number and size of claims which might be made against clergy. For numerous reasons, the number of claims and successful claims seems unlikely to be large. First, the likelihood of clients forming the view that the cleric had breached a duty of care should be considered. Many possible breaches of duty will go unnoticed by clients, as most will lack legal knowledge.

Second, the likelihood of clients acting upon a view that negligence has occurred is relevant. Only a relatively small percentage of patients who suffer unexpected outcomes sue their doctors.<sup>56</sup> The same may apply to clergy. Some may decline to sue clergy due to respect for clergy,<sup>57</sup> or reluctance to become involved in litigation:

Many ... must question whether litigation is a rational course of action given the return for them after deducting irrecoverable solicitor and client costs and taking into account the risks always inherent in litigation.<sup>58</sup>

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<sup>53</sup> Conversations with the author listed in *supra* n. 22.

<sup>54</sup> Eg. Catholic Church Insurances Ltd; Baptist Insurance Association.

<sup>55</sup> See also the comments of MacArthur regarding *Nally* 'the secular media had a field day as the case dragged on for years .... The facts of the case that came out in court received little or no coverage on the network news' - *Introduction to Biblical Counseling*, 5.

<sup>56</sup> Breen, K.J., Plueckhahn, V.D., & Cordner, S.M. 1997 *Ethics, Law and Medical Practice*, Allen & Unwin, Sydney, 73.

<sup>57</sup> Eg. Bergman, 66.

<sup>58</sup> *Perre* per McHugh J at 215.

No win no fee arrangements may mean that the plaintiff will not be charged by their own legal representatives, but cannot protect the plaintiff from being ordered to pay the defendant's costs if the claim is lost.

Fourth, the *CLA* reduces the amount of damages plaintiffs can claim, including in relation to future economic loss and to non-economic loss. It is unnecessary to catalogue the changes here.<sup>59</sup> The result of the changes is that many claims will be reduced in size, but there remains potential for claims to be large.

Fifth, 'the prospect of vexatious or near vexatious litigation is a matter to be considered in fashioning a legal rule'.<sup>60</sup> Churches and clergy could find themselves subjected to claims motivated by religious intolerance or financial greed.

In New South Wales lawyers must not provide legal services unless they reasonably believe, on the basis of provable facts and a reasonable view of the law, that a claim has reasonable prospects of success.<sup>61</sup> This would reduce unmeritorious claims.

It is also worth noting that Edward Barker, who represented the plaintiffs in *Nally*, said in 1980 that fifteen or twenty persons had contacted him hoping to commence clergy malpractice claims, however he was considering taking only one.<sup>62</sup>

## 16.9 Determinacy of liability

The law is concerned to avoid imposition of liability 'in an indeterminate amount for an indeterminate time to an indeterminate class'.<sup>63</sup> Concerns about indeterminacy of liability are not germane to pastoral counselling for depression. Such concerns are usually raised in cases involving pure economic loss where there is no prior relationship between the plaintiff and defendant.<sup>64</sup>

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<sup>59</sup> As to these reductions see sections 17.8 and 17.9.

<sup>60</sup> *Esanda* per McHugh J at 288.

<sup>61</sup> *Legal Profession Act 1987* (NSW) section 198J.

<sup>62</sup> Quoted in Bernhard, M. 'Clerics, Churches Buying Malpractice Insurance' *The Washington Post* 10 October 1980: B10.

<sup>63</sup> *Perre* per Gaudron J at 199. 'It is not the size or number of claims that is decisive in determining whether potential liability is so indeterminate that no duty of care is owed. Liability is indeterminate only when it cannot be realistically calculated. If both the number of claims and the nature of them can be realistically calculated, it cannot be said that [liability is indeterminate]' - *Perre* per McHugh J at 221.

<sup>64</sup> See eg. *Perre* per Hayne J at 303-305.

No professional or other service provider can ever predict with absolute precision exactly how many claims will be made against him or her. Clients to whom clergy provide counselling for depression within a session scheduled for that purpose are not an indeterminate class. Clergy would not be burdened by a spectre of indeterminate liability.

## **Conclusion**

This chapter has argued there is no compelling policy reason to not to impose the postulated duty of care. It is submitted that the possibility of clergy being subject to a duty of care for pastoral counselling for depression would not be unreasonable having regard to the public interest, and seems unlikely to impose an unreasonable burden on clergy.

The degree of care required of clergy would involve little more than compliance with the duty to refer.<sup>65</sup> This does not seem an onerous burden. If both cleric and client wished to engage in pastoral counselling for depression, referral of the client would not prevent this. There does not appear to be any reason to think that a large number of claims will result if the possibility of a duty of care is allowed.

That said, the results of imposing a duty of care cannot be predicted with certainty. There is no hard evidence regarding the ramifications for society of imposing a duty of care on clergy who provide pastoral counselling for depression. In this regard empirical research in Australia would be useful.<sup>66</sup>

It is beyond the scope of the thesis to conduct empirical research. Moreover, it may be the only way in which conclusive empirical evidence as to the effect of imposing a duty of care can be obtained is to do so and observe the results.

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<sup>65</sup> See chapters fourteen and fifteen.

<sup>66</sup> Such research could include investigation of client expectations of and satisfaction with counselling by clergy; the motivation of clients for seeking counselling from clergy; the counselling qualifications and activities of clergy; the referral practices of clergy; the rate of attempted suicide following commencement of treatment among clients (of both pastoral and other counsellors) being advised for depression; the treatment provided to clients who attempt suicide both before and after the event; and treatment provided to clients who do not attempt suicide.

If the results of doing so are thought to be negative, parliament could legislate to overrule its imposition. Where there is a lack of empirical data, some qualified suggestions have been made in this chapter. It is appropriate to do so, rather than ignore some issues. The Court has decided cases without empirical data on public interest issues.<sup>67</sup>

It can be assumed that clergy and churches will not wish to be sued, and this will influence their response to imposition of a duty of care by a court in a particular case, to the extent that liability concerns have not already influenced their practices. It is therefore likely that some clergy would choose not to counsel for depression, or be instructed not to by their church.

It is unlikely, however, that clergy would entirely turn their backs on those who seek help in relation to depression. Rather, they may wish to refer such people to another practitioner. It has not been argued that doing so would create a duty of care.

Many clergy will probably perceive themselves to be insufficiently trained to deal with depression and refrain from doing so for that reason, not merely out of fear of liability. Other clergy may not wish to counsel depressed individuals, for any number of reasons.

Therefore a blanket denial of duty would not necessarily encourage these clergy to provide pastoral counselling for depression, while allowing possibly less responsible clergy to do so with relative impunity. This would promote the interests neither of society nor individual clients.

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In the next chapter the issue of whether breach of the duty to refer could cause a suicide attempt by a client, and therefore damage flowing from the attempt, is considered.

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<sup>67</sup> See for example the remarks made in the absence of empirical data in *Agar* by Gaudron, McHugh, Gummow & Hayne JJ regarding whether changes to the rules of rugby union would be obeyed by players, and whether the changes to the rules would have made the game less attractive to potential participants - at 582-583.

## CAUSAL LINK BETWEEN BREACH OF THE DUTY TO REFER AND DAMAGE RESULTING FROM A SUICIDE ATTEMPT

### Introduction

This chapter examines whether breach of the duty to refer could cause a suicide attempt, and therefore damage resulting from the attempt. Reasons for focussing on this issue have been given.<sup>1</sup>

Other modes of damage, whether arising from breach of the duty to refer or some other breach of duty, are noted in Appendix A. Consideration of causation is ‘complex, difficult and controversial’:

Judges in common law countries can take only the smallest comfort from the fact that determining what caused an injury, for the purposes of legal liability, is also regarded as a most difficult task by the courts of civil law countries. Like courts of the common law, those courts have searched for principles to provide a “filter to eliminate those consequences of the defendant’s conduct for which he [or she] should not be liable”. The search sets one on a path of reasoning which is inescapably “complex, difficult and controversial”. The outcome is a branch of the law which is “highly discretionary and unpredictable”. Needless to say, this causes dissatisfaction to litigants, anguish for their advisers, uncertainty for judges, agitation amongst commentators and friction between health care professionals and their legal counterparts. There are no easy solutions to these problems.<sup>2</sup>

The chapter gives particular attention to the important issue of whether a suicide attempt by a client, being a deliberate act of self-harm, breaks the causal between the counselling negligence of a cleric and damage resulting from the attempt.

Before proceeding to the provisions of the *CLA* dealing with causation, the common sense approach to causation developed by the Court is noted in the first section. As will be seen, that approach remains relevant.

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<sup>1</sup> For reasons explained in the Preface, on page vi, and in section 1.3, on page 5.

<sup>2</sup> *Chappel v Hart* (1998) 195 CLR 232 per Kirby J at 264-265, citations omitted.

## 17.1 Common sense and the ‘but for’ test

The ‘but for’ test means that ‘the defendant’s fault is a cause of the plaintiff’s harm if such harm would not have occurred without (but for) it’.<sup>3</sup> The Court has rejected the ‘but for’ test as the exclusive determinant of causation:

The “but for” test, while retaining an important role as a negative criterion which will commonly (but not always) exclude causation if not satisfied, is inadequate as a comprehensive ... test.<sup>4</sup>

The Court has instead preferred an approach based on common sense:

The common law tradition is that what was the cause of a particular occurrence ... must be determined by applying common sense to the facts of each particular case ... As Dixon CJ, Fullagar and Kitto JJ remarked in *Fitzgerald v Penn* “it is all ultimately a matter of common sense” ...<sup>5</sup>

## 17.2 The *CLA*

Sections 5D and 5E of the *CLA* provide a basis for considering causation. As it relates to causation, the intention of the *CLA* ‘is to guide the courts as they apply a commonsense approach’.<sup>6</sup>

‘It is assumed that in interpreting these provisions the courts will look to ... general principles’.<sup>7</sup> ‘The principles [the *CLA*] embodies in regard to causation are in accord with the common law’.<sup>8</sup>

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<sup>3</sup> Fleming, 219. The *Review of the Law of Negligence* states, at 118, that ‘the basic test of “factual causation” (the ‘but for’ test) is whether the negligence was a necessary condition of the harm’.

<sup>4</sup> *Medlin v State Government Insurance Commission* (1995) 182 CLR 1 per Deane, Dawson, Toohey & Gaudron JJ at 6.

<sup>5</sup> *March v Stramare Pty Ltd* (1991) 171 CLR 506 per Mason CJ at 515 (Toohey, Deane & Gaudron JJ agreeing).

<sup>6</sup> *Parliamentary Debates (Hansard)* Civil Liability Amendment (Personal Responsibility) Bill, Second Reading, 19 November 2002, Mr Egan, Treasurer, Minister for State Development, 6896, 6896.

<sup>7</sup> Balkin, R.P. & Davis, J.L.R. 2004 *Law of Torts* 3rd edn Butterworths Australia, 317.

<sup>8</sup> *Ruddock v Taylor* (2003) 58 NSWLR 269 per Ipp J at 286. Ipp J was one of the authors of the *Review of the Law of Negligence* on which the *CLA* was partly based.

Section 5D of the *CLA* states:

(1) A determination that negligence caused particular harm comprises the following elements:

(a) that the negligence was a necessary condition of the occurrence of the harm (“factual causation”) and

(b) that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused.

(2) In determining in an exceptional case, in accordance with established principles, whether negligence that cannot be established as a necessary condition of the occurrence of harm should be accepted as establishing factual causation, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party;

(3) If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent:

(a) the matter is to be determined subjectively in light of all relevant circumstances subject to paragraph (b); and

(b) any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.

(4) For the purpose of determining the scope of liability the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.

Section 5E of the *CLA* provides:

In determining liability for negligence, the plaintiff always bears the onus of proving, on the balance of probabilities, any fact relevant to the issue of causation.

The *CLA* leaves unchanged the traditional ‘all or nothing’ approach taken by the common law in negligence whereby damages are not available for loss of a chance, for example of recovering from a medical condition, of less than 50%.

Plaintiffs therefore recover nothing in negligence if they cannot prove on the balance of probabilities that the damage was caused by the breach, even if the chance that the damage had been caused by the breach was 49%. Conversely, the plaintiff can recover full damages even if there is a 51% chance that the breach caused the damage:

The question whether the plaintiff has suffered some damage and therefore has a complete cause of action ... is normally established by evidence which satisfies the civil standard of proof. If causation is not established in this way, ... the plaintiff will ... recover nothing.<sup>9</sup>

### 17.3 Presumption of causation from breach and injury

As explained by Gaudron J in *Bennett v Minister of Community Welfare*, this means:

Although it is sometimes necessary for a plaintiff to lead evidence as to what would or would not have happened if a particular common law duty had been performed, generally speaking, if an injury occurs within an area of foreseeable risk, then, in the absence of evidence that the breach had no effect, or that the injury would have occurred even if the duty had been performed, it will be taken that the breach of the common law duty caused or materially contributed to the injury.<sup>10</sup>

This approach has sometimes been referred to as ‘shifting the evidentiary onus’ in relation to causation from the plaintiff to the defendant.<sup>11</sup> The *Review of the Law of Negligence* was critical of the passage by Gaudron J, and stated:

The effect of this approach is to cast the onus of proof on the issue of causation onto the defendant ... This principle, which has been referred to with approval by various courts in recent cases, represents a fundamental change in traditional about causation and proof of causation, and has the potential significantly to expand liability for negligence ... A legislative restatement of the basic rule that the onus of proof of any fact relevant to causation always rests on the plaintiff may discourage courts from adopting this approach.<sup>12</sup>

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<sup>9</sup> *Chappel* per Gummow J at 258. Some members of the Court have expressed support for an approach to causation which would enable ‘a plaintiff to recover damages to be equated with, and reduced to the value of the chance he or she lost, rather than the damages which would be appropriate if it has been proved on the balance of probabilities that the plaintiff’s condition owes itself to the defendant’s acts or omissions - *ibid* per Callinan J at 807. Similarly see *Chappel* per Gaudron J at 239, per Kirby J at 274. However this approach did not have majority support even before the retirement of Gaudron J.

<sup>10</sup> (1992) 176 CLR 408 per Gaudron J at 420-421.

<sup>11</sup> Eg. *Chappell* per Kirby J at 273.

<sup>12</sup> *Review of the Law of Negligence*, 112.

The ‘legislative restatement’ called for by the *Review of the Law of Negligence* does not draw a distinction between the legal onus and the evidentiary onus, but merely refers to ‘the onus’:

The Proposed Act should embody the following principles ... Onus of proof ... The plaintiff always bears the onus of proving, on the balance of probabilities, any fact relevant to the issue of causation.<sup>13</sup>

In relation to the onus of proof for causation, the *CLA* has adopted the language recommended by the *Review of the Law of Negligence*.<sup>14</sup> The absolute language used - ‘the plaintiff always bears the onus of proving ... any fact relevant to the issue of causation’ - would appear to preclude the shifting of the evidentiary onus to the defendant. Whether it has the support of a majority of the Court is therefore of academic relevance only.<sup>15</sup>

#### 17.4 Factual causation

The ‘but for’ test is harder to satisfy in the case of negligent omissions than negligent acts, because it is necessary to determine what would have happened had something been done, rather than simply observe the consequences of a negligent act:

Especially in the case of culpable *omission*, it becomes harder to show that “but for it” the injury would have been avoided.<sup>16</sup> (emphasis in original)

Applying the ‘but for’ test to the whether breach of the duty to refer could cause a suicide attempt by a client involves asking whether, were it not for the cleric’s omission to refer the client to a general practitioner or mental health professional, the client would have suffered unnecessarily prolonged depression and made the suicide attempt.

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<sup>13</sup> *Review of the Law of Negligence*, 117.

<sup>14</sup> See section 5E of the *CLA* in section 17.2 above.

<sup>15</sup> It appears that it does not have majority support, particularly with the retirement of Gaudron J. In *Bennett*, Mason CJ, Deane and Toohey JJ expressly declined to consider whether an approach whereby the evidentiary onus of proof is reversed should be adopted - at 416. McHugh J seemingly accepted it in *Chappel* at 244; Gummow J applied it in *Chappel* - at 257. Kirby J expressed support for this approach in *Chappel* at 273. See also Villa, 63-64.

<sup>16</sup> Fleming, 352. See also *Bennett* per Gaudron J at 420: ‘a case based on omission ... will, in certain respects, fall for analysis in a way that differs from that appropriate for a case based on a positive act’.

This will in turn involve asking whether, had referral occurred: (1) the plaintiff would have attended the general practitioner or mental health professional; (2) the general practitioner or mental health professional would have recommended one or more of the main treatments for depression; (3) the plaintiff would have tried one or more of those treatments; (4) one or more of those treatments would have lead to improvement in the plaintiff's depression sufficient to have averted the suicide attempt, which would not necessarily mean complete elimination of the depression; and (5) the suicide attempt was due to the depression, not some other cause. Each of matters (1) to (5) will be considered in turn below.

#### **17.4.1 Proof that the client would have attended a general practitioner or mental health professional if referred**

‘Courts in Australia have adopted a subjective approach which has regard to what the particular patient’s response would have been had the proper information been given’.<sup>17</sup>

The *CLA* does not change that. As already seen, however, it provides that ‘any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest’.<sup>18</sup>

All other circumstances will be relevant to whether referral would have caused the plaintiff to attend a general practitioner or mental health professional,<sup>19</sup> which may be a difficult question:

[T]hough it may be indirect ... the loss and damage must none the less be causally related to the want of care. Thus, it will not be recoverable if it flows entirely from an independent exercise of judgment on the part of the claimant uninfluenced by the information or advice given. Whether or not it does so in any given case may constitute a serious and difficult question of fact.<sup>20</sup>

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<sup>17</sup> *Chappel* per Kirby J at 272.

<sup>18</sup> Section 5D (3) (b).

<sup>19</sup> Section 5D (3) (a).

<sup>20</sup> *MLC* per Barwick CJ at 568.

The continued attendance of counselling may evidence reliance upon it. People seek help from others because they cannot solve their problems themselves. Thus a client might have a predisposition towards relying on pastoral counselling for depression, and thus be likely attend another practitioner to which they were directed by the cleric.

The cleric might give evidence that the client had an overall tendency not to rely on the counselling, and thus would not have consulted a general practitioner or mental health professional even if referred. Evidence as to the affordability and geographic accessibility of a general practitioner or mental health professional would also be relevant to whether a client would have attended.

#### **17.4.2 Proof that a general practitioner or mental health professional would have recommended one or more of the main treatments**

It appears likely that a general practitioner or mental health professional would recommend one or more of the main treatments for depression to a depressed client. It should be noted, however, that among mental health professionals, only psychiatrists can prescribe medication,<sup>21</sup> and not all mental health professionals are proficient in the provision of cognitive behavioural therapy.<sup>22</sup>

#### **17.4.3 Proof that the client would have used treatments recommended by a general practitioner or mental health professional**

A defendant could argue that the side-effects of a particular treatment would have dissuaded the client from using it. The personal preferences of the client will also be relevant. Thus if there is evidence that a client had a strong preference for a religious solution, a defendant could argue that the client would have been unlikely to use non-religious treatments or solutions even if referred.

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<sup>21</sup> *NHMRC Guidelines*, 86.

<sup>22</sup> *Ibid.*, 73.

#### **17.4.4 Proof that a treatment would have led to improvement sufficient to have averted the suicide attempt if used**

There is evidence that virtually all depressed clients will respond to some form of treatment.<sup>23</sup> Parker states that depression is ‘treatable’.<sup>24</sup> This suggests that depression can often be treated sufficiently effectively to avert suicide attempts.

The quantity and quality of data proving the effectiveness of each treatment that might have been used if the client was referred will be relevant to whether the client can establish sufficient causal link between failure to refer and a suicide attempt.

Evidence as to the cause, type, severity and chronicity of the *client’s* depression, and any past unresponsiveness of the client to medication or cognitive behavioural therapy would also be relevant.

There are many difficulties in measuring the effectiveness of treatments for depression, such as the dependence of data on subjective perceptions, and the complexities of human nature.<sup>25</sup> Nonetheless anti-depressants have been found to be effective.<sup>26</sup>

Anti-depressant medication might relieve depression for no physiological reason. Placebo responses in general are high among depressed patients.<sup>27</sup> Whether the improvement is due to the anti-depressant itself or a placebo effect does not matter for the purposes of assessing causation - the point is not how a treatment would have led to improvement but whether it would have led to improvement.

Human nature is complex and a large number of circumstances in a depressed client’s life may determine whether the client remains depressed. Nonetheless, a large number of variable in a client’s life does not mean that changing only one or two variables (by trialing a particular treatment) cannot make a significant difference.

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<sup>23</sup> Beutler, Clarkin & Bongar, 8.

<sup>24</sup> Parker, 2002, xii. Citing 15 studies, Beutler, Clarkin and Bongar state (at 292) that it is common to reduce the symptoms of depression to subclinical among 65 percent to 70 percent of patients with major depression, at least by the time treatment is ended.

<sup>25</sup> See generally Beutler, Clarkin & Bongar, 261-289.

<sup>26</sup> See eg. *APA Guideline*, Part A, III, A. 8.

<sup>27</sup> See also Beutler, Clarkin & Bongar, 273.

Where a client of a cleric attempts suicide due to depression and sustains physical injury, then recovers from the depression after attending another practitioner and using a new treatment, it will be easier for a client to prove that had the defendant referred the client sufficient recovery would have occurred than if a client attempted suicide and remained depressed up until the time of trial.

For example if a client survived a suicide attempt, the client could consult a new practitioner who might recommend an anti-depressant or cognitive behavioural therapy. If the client did so and recovered, this would support a conclusion that referral would or might have caused improvement had it occurred.

In such cases defendants might argue that the improvement was due to some other factor, not the new treatment. For example a defendant could argue, since the rate of spontaneous recovery from depression is said to be 'high',<sup>28</sup> that the plaintiff's recovery was spontaneous, and not due to the new treatment.

The defendant may also argue that some negative factor in the plaintiff's life causing or contributing to the depression had been removed, or that positive external factors alleviating the depression had arisen at the same time the new treatment was undertaken.

For example common sense might suggest that a new job or new relationship could alleviate depression, depending on the cause of the depression, rather than the new treatment. Defendants could seek expert medical reports in this regard.

It would be mathematically incorrect to merely add up the probabilities that each of the treatments would have been effective. If for example there were three such treatments, then to take account of the fact that it is possible that none, all, or any one or any two of them could have worked, it is necessary to have recourse to probability theory.

The probability of one or more of them resulting in sufficient improvement for the suicide attempt not to have occurred if tried would be 100% (or 1) minus the probability of *none* of them working.<sup>29</sup> The probability of sufficient improvement *not* occurring is calculated by multiplying the probabilities that each of the treatments that the client would have tried if referred would have failed.<sup>30</sup>

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<sup>28</sup> Beutler, Clarkin & Bongar, 273.

<sup>29</sup> See eg. Everitt, B.S. 1999 *Chance Rules: An Informal Guide to Probability, Risk and Statistics* Springer-Verlag New York Inc., 24-25. In probability theory, an event which has a 100% chance of happening is assigned the probability of 1. An event which is certain *not* to happen has a probability of zero. An event which is 40% likely to happen has the probability of 0.4 and so on.

<sup>30</sup> *Id.*

Clearly, application of probability theory to complex fact situations can be difficult. The Court has previously undertaken calculations based on probability theory, for example in *Malec v Hutton*<sup>31</sup> and *G v H*.<sup>32</sup>

Even so, applying probability theory to a case involving breach of the duty to refer where pastoral counselling for depression was being provided may be so complex that the Court would decline to do so. Regarding the extent to which probability theory should be used by courts it has been stated:

Courts should generally rely on commonsense inferences drawn from whole sets of circumstances rather than numerical calculations of probability; but on the other hand ... some understanding of probability theory is helpful in using commonsense reasoning, and can also promote avoidance ... of mistakes.<sup>33</sup>

#### **17.4.5 Proof that the suicide attempt was due to depression**

Empirical data suggests that depression is ‘a major risk factor for suicide’.<sup>34</sup> It is unlikely that a court would infer from this alone that a particular client was depressed at the time of a suicide attempt and that the depression was the cause of the attempt.<sup>35</sup>

Evidence regarding the particular client would be required, because there may be other explanations for the suicide attempt. For example the client may have had a physical medical condition and wished to commit suicide because of constant physical pain rather than depression.

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<sup>31</sup> (1990) 169 CLR 638 per Deane, Gaudron & McHugh JJ at 645.

<sup>32</sup> (1994) 68 ALJR 860 per Deane, Dawson & Gaudron JJ at 855-866. In that case the context was not multiple medical treatments, but paternity, and the multiple contraceptive methods used by a woman during her activities as a prostitute but not during those with her boyfriend. Their Honours stated: ‘If the probability of the combined contraceptive methods *not* failing on any given occasion is assumed to be 999 chances in 1,000, or 0.999, then the probability of their failing at least once on 250 independent occasions is  $1 - (0.999)^{250}$  or about 0.22.’

<sup>33</sup> Hodgson, D. ‘A Lawyer Looks at Bayes’ Theorem (2002) 76 *ALJ* 109, 113.

<sup>34</sup> *NHMRC Guidelines*, 66. See also Beutler, Clarkin & Bongar at 303: ‘Psychological autopsies suggest that a many as 93 percent of patients who commit suicide may have qualified for a psychiatric disorder immediately before the suicide ... The two diagnoses whose presence is most strongly related to completed suicide are depressive disorders and alcohol abuse ... Of the two, depressive disorder has consistently been the more common indicator and the stronger predictor of suicide’.

<sup>35</sup> Existence of both negligence and sufficient causal link may be inferred by courts: ‘where direct proof is not available it is enough if the circumstances appearing in evidence give rise to a reasonable and definite inference; they must do more than give rise to conflicting inferences of equal degree of probability so that the choice between them is mere conjecture’ - *Holloway v McFeeters* (1956) 94 CLR 470 per Williams, Webb & Taylor JJ at 480-481.

Alternatively, the plaintiff may have been depressed at the time of the attempt, but the attempt may have occurred soon after some substantial negative event such as a bereavement. The defendant would argue that it was the supervening event which caused the attempt, whereas a plaintiff might argue they could have withstood the event if less depressed.

It may be that a client attempts suicide months or years after the alleged breach of the duty to refer. The lapse of time is not itself crucial,<sup>36</sup> however in such cases the plaintiff may have recovered then relapsed, possibly more than once, or been exposed to numerous distressing life events. Where they applied, these factors would make the plaintiff's task in proving causation even more difficult.

#### 17.4.6 Further probability theory

If there was evidence regarding events (1) to (5) identified in section 17.4, numerical probabilities as to each of them happening could be assigned by a court.<sup>37</sup> Even if it could be proved that the probability of each of the events occurring was more than 50%, the probability of them *all* occurring could still be less than 50%.

For example, if the probability of each of these individual events happening was quite high, say 80% (0.8), the probability of them *all* occurring would still only be  $0.8 \times 0.8 \times 0.8 \times 0.8 \times 0.8$  which equals 0.33 or 33%.<sup>38</sup>

Thus in this hypothetical example the plaintiff would not have proved factual causation if a strict probabilistic approach was used, however courts usually do not take such an approach and the *CLA* would not appear to compel such an approach.<sup>39</sup> In any event, it appears that if a relevant case arose a plaintiff might have considerable difficulty in establishing factual causation on the balance of probabilities.

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<sup>36</sup> A lapse of time of 18 months or longer was deemed of little importance in a number of cases referred to in section 17.6.1 below.

<sup>37</sup> In *G v H* (1990) 169 CLR 638, Brennan & McHugh JJ (at 861), (in contrast to Deane, Dawson & Gaudron JJ at 645) refused to make any assumption about the probability of the contraceptive methods failing in the absence of evidence. However this refusal was due to complete absence of evidence, not the fact that precise numerical probabilities cannot be assigned to events. Courts routinely assign precise probabilities, even if estimation has to be used.

<sup>38</sup> See eg. Everitt, 24-25.

<sup>39</sup> The *Review of the Law of Negligence* is silent on this issue.

In the next section whether breach of the duty to refer may be accepted as establishing factual causation of a suicide attempt even if not a necessary condition of that event is considered.

### **17.5 Factual causation where the negligence is not a necessary condition of the occurrence of the harm**

The *CLA* permits courts to accept negligence which is not a necessary condition of the occurrence of the alleged harm as sufficient to establish factual causation in an ‘exceptional’ case:

In determining in an exceptional case, in accordance with established principles, whether negligence that cannot be established as a necessary condition of the occurrence of harm should be accepted as establishing factual causation, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.<sup>40</sup>

The *CLA* affords limited guidance as to which cases are ‘exceptional’. While not conclusive of the issue, the *Review of the Law of Negligence* gives two examples of cases which might be regarded as ‘exceptional’. The first involves ‘material contribution to harm’ meaning:

[H]arm which is brought about by the cumulative operation of two or more factors, but which is indivisible in the sense that it is not possible to determine the relative contribution of the various factors to the total harm suffered.<sup>41</sup>

The second involves ‘material contribution to risk’ whereby:

[P]roof (on the balance of probabilities) that the defendant’s negligent conduct “materially increased the risk” that the [plaintiff would suffer the harm alleged] would suffice to establish a causal connection between the conduct and the harm. The status of this principle in Australian law is unclear. The High Court has not yet had a chance to consider it ... The Panel’s opinion is that, in certain types of cases, bridging the evidentiary gap in this way would be widely considered to be fair and reasonable.<sup>42</sup>

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<sup>40</sup>Section 5D (2).

<sup>41</sup>*Review of the Law of Negligence*, 109.

<sup>42</sup>*Ibid* 110.

The second of these examples is of greater relevance to pastoral counselling for depression. It remains true that its status in Australian law is unclear.

It could be argued that where a cleric provides pastoral counselling for depression and does not comply with the duty to refer the cleric's conduct has increased the risk to the client, if the client has been diverted or delayed from using the main treatments for depression. Similarly if it is alleged that the cleric exacerbated the depression in some way which amounted to a breach of duty, it could be argued the risk to the client was increased.

It could thus be argued that even if breach of the duty to refer cannot be proved on the balance of probabilities to have been a necessary condition to a suicide attempt, it should be accepted as establishing factual causation of the attempt.

### **17.6 The appropriateness that the cleric's liability extend to injury from attempted suicide**

The *CLA* stipulates that it must be 'appropriate for the scope of the negligent person's liability to extend to the harm so caused'.<sup>43</sup> What is appropriate is essentially a matter for the courts:

For the purpose of determining the scope of liability the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.<sup>44</sup>

This appears to be a restatement in different words of the common law position:

The [but for] test, applied as an exclusive criterion of causation, yields unacceptable results ... the results which it yields must be tempered by the making of value judgments and the infusion of policy considerations.<sup>45</sup>

The reference to 'scope of liability' in the *CLA* subsumes the common law concept of remoteness of damage.<sup>46</sup>

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<sup>43</sup>Section 5D (1) (b).

<sup>44</sup>Section 5D (4).

<sup>45</sup>*March* per Mason CJ at 515 (Toohey, Deane & Gaudron JJ agreeing).

<sup>46</sup>It is clear from the discussion in the [*Review of the Law of Negligence*] that the scope of liability requirement is intended to encompass what, at common law, would have been referred to as the "remoteness of damage" issue. Both involve a determination

It could be argued that it would not be appropriate for a cleric to be held liable for a client's suicide attempt when there were other factors contributing to the attempt, such as the client's depression and perhaps other events in the client's life. This is not a valid argument. To accept it would be like holding a doctor not liable for a negligent failure to treat a patient's cancer because the doctor did not cause the cancer.

It could also be argued that it would not be appropriate to hold the cleric liable because the suicide attempt is an intervening act which breaks the chain of causation. Such an argument would probably not succeed in Australia.

This is because authority of the Court suggests that where part of the defendant's duty is to minimise or protect a plaintiff from a risk, or arises partly from a risk, then materialisation of the risk as a result of an intervening action will be unlikely to break the causal chain. In *March* Mason CJ stated:

In some situations a defendant may come under a duty of care not to expose the plaintiff to risk of injury arising from deliberate or voluntary conduct or even to guard against that risk ... *To deny recovery in those situations because the intervening action is deliberate or voluntary would be to deprive the duty of any content ...* The fact that the intervening action was foreseeable does not mean that the negligent defendant is liable for damage which results from the intervening action ... *But is otherwise if the intervening action was in the ordinary course of things the very kind of thing likely to happen as a result of the defendant's negligence.*<sup>47</sup>  
(emphasis added)

Similarly in *Chappel* Gaudron J stated:

It is contrary to common sense to treat part of the very risk which called the duty into existence as an event breaking the chain of causation beginning with the breach of that duty.<sup>48</sup>

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of which consequences of negligent conduct a defendant is to be held liable for' - Villa, 58. Under the concept of remoteness of damage a plaintiff can recover for all damage of a foreseeable kind that flows from the breach of the duty, even of only the general kind was foreseeable and not the particular nature, extent and manner of infliction - *The Wagon Mound No. 1* [1961] AC 388. 'That it is sufficient that the class of injury as distinct from the particular injury ought to be foreseen as a possible consequence of particular conduct in order to establish liability ... for the particular injury is well established' - *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383 per Barwick CJ at 390.

<sup>47</sup> *March* per Mason CJ at 517-518.

<sup>48</sup> *Chappel* per Gaudron J at 240.

In *Chappel Gummow J* gave an example of the principle referred to by Gaudron J: where the law imposes a duty which includes taking precautions against burglars, breach of the duty by leaving a door open will cause the loss of property stolen even though in a prosecution for theft causation would have been attributed to the thief.<sup>49</sup>

McHugh J recently stated, consistently with the comments of Mason CJ, Gaudron and Gummow JJ above:

The common law regards individuals as autonomous beings who are entitled to make, but are legally responsible for, their choices. But like all common law doctrines, there are exceptions. One of the most important is that a person will seldom be held legally responsible for a choice if another person owes the first person an affirmative duty of care in relation to the area of choice.<sup>50</sup>

The risk of attempted suicide is part of the risk from which the duty of those who provide counselling for depression arises. Attempted suicide is the very kind of thing which could happen due to negligence in counselling depressed or suicidal people.

Holding that a suicide attempt by a client being counselled for depression automatically breaks the chain of causation between breach of duty by the cleric and injuries sustained would deprive the duty of much of its rationale.

It could also be argued that it would not be appropriate to make a cleric liable for injury from a suicide attempt because attempting suicide is unreasonable. This issue is considered in the next section.

### **17.6.1 The ‘unreasonableness’ of a suicide attempt**

In the New South Wales Court of Appeal case, *AMP v RTA & Anor*, Spigelman CJ noted that there are cases in which a duty of care extends to the ‘prevention’ of deliberate acts of self-harm.<sup>51</sup>

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<sup>49</sup> *Ibid* per Gummow J at 256.

<sup>50</sup> *Cole* per McHugh J at 483.

<sup>51</sup> *AMP v RTA & Anor* (2001) ATR 67, 214 per Spigelman CJ at 67,219. His Honour cited some English authorities discussing duties owed to children playing with dangerous objects and the situation where a person commits self-harm due to something which the defendant has done or is doing to the person. These situations are not relevant to this thesis. The facts and judgments in *AMP* are not of sufficient relevance to this thesis to warrant discussion beyond that undertaken in this section.

His Honour stated however:

Deliberate self-infliction of harm should generally be seen to break the causation link ...  
Actions involving the deliberate infliction of self harm should generally be regarded as  
“independent and unreasonable” and as a break in the ... chain ...<sup>52</sup>

For the reasons given in the previous section, it is suggested that this statement will not apply to counselling for depression. Further consideration of it is nonetheless worthwhile.

In support of his statement, Spigelman CJ noted that the Court uses a common sense test for causation based on common sense, policy and value judgments play a part.<sup>53</sup> While Spigelman CJ did not elaborate on the applicable policy or value, Lord Denning M.R. has spoken on this issue:

I feel it is most unfitting that the personal representatives of a suicide should be able to claim damages in respect of his death. At any rate, when he succeeds in killing himself. And I do not see why he should be in any better position when he does not succeed. By this act - in self-inflicting this grievous injury - he has made himself a burden on the whole community. Our hospital ... and our social welfare services ... will do all they can to help him and his family ... I see no justification ... in his being awarded ... 200,000 [pounds] ... Such a sum will have to be raised, in the long run, by society itself ... The policy of the law should be to discourage these actions. I would disallow them altogether ... rather than burden the community with them.<sup>54</sup>

This policy is of some relevance to cases where counselling for depression is provided. In its desire not to encourage suicide attempts and therefore protect life and reduce the burden to the community, it is valid.

Yet it is self-defeating, in that if the policy was applied then clergy and other relevant practitioners would have less incentive to exercise reasonable care when counselling a depressed person because there would be less chance of a successful action being brought against them. This may increase, not decrease the risk to clients and the burden to the community.

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<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Hyde v Tameside Area Health Authority* (1981), reported at (1986) 2 P.N. 26, 29-30; quoted in Jones, M.A. 1991 *Medical Negligence* Sweet & Maxwell London, 156 - 157.

Further, while payment of compensation to persons who attempt suicide may burden the community through increases to insurance premiums, the community will in any event be burdened by the plaintiff's use of the hospital and social welfare services. If the plaintiff received compensation (if the other requirements of liability were satisfied), the plaintiff may be in a position to pay for such services rather than rely on the taxpayer.

Additionally, statute law recognises that the capacity of some mentally ill people to exercise sound judgment may be so disturbed that involuntary commitment to a hospital for their own safety is required.<sup>55</sup> Consistency requires that this impaired ability to make judgments be acknowledged by the law of negligence.

Lord Denning's view was unanimously rejected by the English Court of Appeal in *Kirkham v Chief Constable of the Greater Manchester Police*.<sup>56</sup> It was held that suicide attempt by a person who is 'not of sound mind' does not constitute either voluntary assumption of risk or a break in the causal chain:

Where a man of sound mind commits suicide, his estate would be unable to maintain an action ... But in the present case Mr Kirkham was not of sound mind. True, he was sane in the legal sense. His suicide was a deliberate and conscious act. But Dr Sayed, whose evidence the judge accepted, said that Mr Kirkham was suffering from clinical depression. His judgment was impaired ... I would reject the defence of *volenti non fit injuria* ... The Suicide Act 1961 does more than abolish the crime of suicide. It is symptomatic of a change in the public attitude towards suicide generally. It is no longer regarded with the same abhorrence it once was ... The fact that aiding and abetting suicide remains a crime ... does not diminish the force of the argument ... I would hold that the defence of *ex turpi causa* is not available in these cases, at any rate where ... there is medical evidence that the suicide was not in possession of his mind.<sup>57</sup>

As to Lord Denning's view Lloyd LJ stated:

I have respect for that view. But I do not share it. The Court does not condone suicide. But ... I would not regard Lord Denning's judgment ... as standing in the way of the view I have formed.<sup>58</sup>

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<sup>55</sup> *Mental Health Act 1990* (NSW) sections 21 and 23.

<sup>56</sup> [1990] 2 WLR 987.

<sup>57</sup> *Ibid* per Lloyd LJ at 992-994.

<sup>58</sup> *Ibid* per Lloyd LJ at 995. Farquharson LJ's judgment was similar. Sir Denys Buckley agreed with Lloyd and Farquharson LJJ.

Returning to Spigelman CJ's judgment in *AMP*, his Honour cited comments by Mason CJ and McHugh J respectively in support of his conclusion that an 'unreasonable' intervening act breaks the causal chain:

In truth the decision [in *M'Kew v Holland* [1970] SC (HL) 20] proceeded from a conclusion that the plaintiff's injury was the consequence of his independent and unreasonable action [in descending a staircase without a handrail with a leg injury caused by the defendant].<sup>59</sup>

The common law concept of commonsense causation accepts that the chain of causation ... is broken ... if there has been an intrusion of a new cause which disturbs the sequence of events, something which can be described as either unreasonable or extraneous or extrinsic.<sup>60</sup>

Nonetheless, it is arguable that the 'unreasonableness' of suicide is not relevant. As four members of the Court indicated in *Medlin* in relation to whether the decision of a man injured by the defendant to resign from his job barred him from claiming damages for loss of earning capacity:

With due respect [to the courts below] ... the question whether a sixty-year-old man who has sustained permanently incapacitating injuries of the kind sustained by the plaintiff "should" continue in his employment or is "acting reasonably" in accepting premature retirement *was not the appropriate one*.<sup>61</sup> (emphasis added)

The question should always be whether, as a matter of common sense, the breach of duty caused the suicide attempt. As the same four members of the Court said in *Medlin*:

The ultimate question must, however, always be whether, notwithstanding the intervention of the subsequent decision, the defendant's wrongful act or omission is, as between the plaintiff and the defendant and as a matter of commonsense and experience, properly to be seen as having caused the relevant loss.<sup>62</sup>

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<sup>59</sup> *March* per Mason CJ at 517.

<sup>60</sup> *Bennett* per McHugh J at 429.

<sup>61</sup> *Medlin* per Deane, Dawson, Toohey & Gaudron JJ at 11.

<sup>62</sup> *Ibid* 6.

Similarly Gaudron J stated in *Bennett*:

The question whether some supervening event broke a chain of causation which began with or which relates back to ... a failure to perform a positive duty, is one that can only be answered by having regard to what would or would not have happened if the duty had been performed.<sup>63</sup>

In other words, it is necessary to consider not whether the plaintiff's suicide attempt was reasonable, but whether it would or would not have occurred if the defendant had complied with the standard, having regard to the circumstances.

The proposition that the circumstances must be considered, as opposed to merely whether a suicide attempt is 'reasonable', is arguably further supported by *Chapman v Hearse*. In that case Dr Cherry was struck by a negligently driven car while trying to help a person injured in an accident caused by the negligence of another driver. Five members of the Court stated:

It was ... said ... Hearse's negligent driving operated to break the chain of causation between the original negligent act and Dr Cherry's death. Whether this was so or not must, we think, *be very much a matter of circumstance and of degree.*<sup>64</sup> (emphasis added)

Whether a person who attempts suicide is sane or insane, or views suicide as right or wrong, is arguably no more definitive of whether the defendant caused the suicide attempt than whether the attempt was 'unreasonable'. In *AMP Davies AJA* expressed the view that a finding of insanity was not necessary to maintain the continuity of the causal chain between negligence and a suicide attempt:

The law recognises in contexts not involving insanity that the will may be overborne or subjected to such influences that, although an act is deliberate, it is not regarded as the actor's intentional act.<sup>65</sup>

If the client was suffering from depression at the time of the suicide attempt and the depression materially contributes to the attempt, then it is consistent with common sense to hold that the attempt does not break the causal chain.

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<sup>63</sup>*Bennett* per Gaudron J at 421.

<sup>64</sup>(1961) 106 CLR 112 per Dixon CJ, Kitto, Taylor, Menzies & Windeyer JJ at 122.

<sup>65</sup>*AMP* per Davies AJA at 67, 251.

This is so regardless of whether the attempt is a deliberate, voluntary or conscious act, or of the ‘saneness’ of the client. There are a number of state decisions which support this reasoning.

In *Lisle v Brice*<sup>66</sup> the plaintiff’s husband sustained injuries in a car accident which led to ‘major depression’. Williams JA, with whom McMurdo P and Thomas JA agreed, in the Queensland Court of Appeal held that the accident was the cause of his suicide three years later.<sup>67</sup> This was despite the fact that other events in his life, such as an altercation involving the police and business difficulties, probably contributed to his suicide.<sup>68</sup>

Williams JA considered *March*, *Chapman* and *Medlin* and then stated ‘in light of the High Court authorities to which I have referred’ the proposition that a suicide attempt by a plaintiff breaks the chain of causation ‘cannot stand’.<sup>69</sup>

In *NSW Insurance Ministerial Corp v Myers*<sup>70</sup> the plaintiff suffered serious injuries in a motor vehicle accident. He suffered depression, his marriage broke down and there was alcohol abuse. Four years after the accident he took an overdose of pills in a suicide attempt which caused brain damage and quadriplegia.

Cole JA in the New South Wales Court of Appeal, with whom Meagher JA agreed, applied *Medlin* and concluded that the suicide attempt did not break the causal chain between the motor vehicle accident and the brain damage and quadriplegia.<sup>71</sup> Mahoney JA reached the same conclusion.<sup>72</sup>

In *Telstra Corporation Limited v Smith* the plaintiff fell into a pit which was managed by the defendant and sustained injury.<sup>73</sup> He became depressed due to the injuries, attempted suicide by electrocution and sustained brain damage.

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<sup>66</sup>(2001) 34 *Motor Vehicle Reports* 206.

<sup>67</sup>*Ibid* per Williams JA at 208-219.

<sup>68</sup>*Ibid* per Thomas JA at 207-208.

<sup>69</sup>*Lisle* at 217.

<sup>70</sup>(1995) 21 *Motor Vehicle Reports* 295.

<sup>71</sup>*Myers* at 302-303.

<sup>72</sup>*Ibid* at 298.

<sup>73</sup>(1998) *Australian Torts Reports* 81-487.

The New South Wales Court of Appeal held that the suicide attempt did not break the chain of causation between the accident and the brain damage.<sup>74</sup> The precise time lapse between the original accident and the attempted suicide is not stated in the reasons; it appears to have been some years.

In the old Victorian case of *Haber v Walker*<sup>75</sup> the question was whether a car accident caused by the defendant in which the deceased was severely injured caused the deceased's suicide eighteen months later.

The Victorian Supreme Court held that the suicide did not break the causal chain because the accident had caused the deceased to become insane and therefore unable to know that suicide was wrong.<sup>76</sup> In the circumstances of that case, the lapse of time between the accident and the suicide was of little importance.<sup>77</sup>

### **17.7 Is a suicide attempt contributory negligence?**

It could be argued by a defendant that a client's suicide attempt represents contributory negligence in that it constitutes a failure to take reasonable care for their own safety. As to when a finding of contributory negligence may be made, Gleeson CJ, McHugh, Gummow and Hayne JJ stated:

A finding of contributory negligence turns on a factual investigation of whether the plaintiff contributed to his or her own loss by failing to take reasonable care for his or her person or property. What is reasonable care depends upon the circumstances of the case. In many cases, it may be proper for the plaintiff to rely on the defendant to perform its duty. But there is no absolute rule. The duties and responsibilities of the defendant are a variable factor in determining whether contributory negligence exists and, if so, to what degree. In some cases, the nature of the duty owed may exculpate the plaintiff from a claim of contributory negligence, in other cases the nature of that duty may reduce the plaintiff's share of responsibility ... and in yet other cases the nature of the duty may not prevent a finding [of contributory negligence].<sup>78</sup>

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<sup>74</sup> *Ibid* per Rolfe AJA at 65,262-65,263, Priestley & Sheller JJA agreeing.

<sup>75</sup> [1963] VR 339.

<sup>76</sup> *Haber* per Lowe J at 352, Smith J agreeing at 354.

<sup>77</sup> *Ibid* per Lowe J at 349.

<sup>78</sup> *Astley* at 14.

Thus at common law the mere fact that the duty to refer is designed to reduce the risk of suicide, along with reducing the risks of other harm associated with depression, does not mean that a suicide attempt could not constitute contributory negligence.

Nonetheless, if the Court were to view depression as a medical illness affecting the capacity of a client to exercise judgment and make appropriate decisions then it may be unlikely to view a suicide attempt as contributory negligence.

The *CLA* contains a provision relating to contributory negligence, which states:

The principles that are applicable in determining whether a person has been negligent also apply in determining whether the person who suffered harm has been contributorily negligent in failing to take precautions against the risk of that harm ... For that purpose ... the standard of care required of the person who suffered harm is that of a reasonable person in the position of that person ...<sup>79</sup>

Applying the same standard of care, that of the reasonable person, for negligence and contributory negligence, 'does not require a court to ignore the particular attributes of the plaintiff, nor of the relationship between the plaintiff and defendant'.<sup>80</sup>

Thus the depressed and suicidal state of mind of a client who attempts suicide may be considered in determining whether the client was guilty of contributory negligence, although to some extent it seems inapposite to consider how a reasonable person in that position would act.

Alternatively, it could perhaps be argued that this section should not be applied to a suicide attempt by a depressed client, and should be interpreted in such a way that it only applies where an act or omission by a plaintiff is capable of constituting contributory negligence at all, whereas a suicide attempt by a depressed client is not something which amounts to contributory negligence.

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<sup>79</sup>Section 5R (1) - (2).

<sup>80</sup>Villa, 118.

The *CLA* provides that contributory negligence can defeat a claim entirely if the court thinks it ‘just and equitable’ to do so.<sup>81</sup> It could be argued that it is not just and equitable for a client’s claim to be defeated on the basis that the suicide attempt is contributory negligence.

Further, if a suicide attempt by a client defeated a claim for damages for injury arising from the attempt then mental health professionals could never be liable in this respect. It is doubtful that the legislature intended such a result.

If it was proved that the breach of the duty to refer caused a suicide attempt by a client it would be necessary for the plaintiff to prove that the attempt caused the damage alleged, and to assess that damage. These issues are considered below.

### **17.8 Physical injury**

As a general proposition a suicide attempt could obviously cause physical injury. It would remain for the plaintiff to establish that the suicide attempt caused the injuries alleged in the particular case. The existence and extent of physical injuries and disabilities arising from a suicide attempt could be proved through medical reports, as in other personal injury cases.

Non-economic loss is defined by the *CLA* as pain and suffering, loss of amenities of life, loss of expectation of life and / or disfigurement.<sup>82</sup> The *CLA* limits the damages for non-economic loss.<sup>83</sup>

### **17.9 Economic loss consequent to physical injury**

Physical injury may lead to economic loss, for example from disruption to employment. The plaintiff would need to establish that the physical injury led to the economic loss alleged. Economic loss is a well known common law head of damages.

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<sup>81</sup>Section 5S.

<sup>82</sup>Section 3.

<sup>83</sup>Section 16 (1) provides that no damages are to be awarded for non-economic loss unless the severity of the non-economic loss is at least 15% of ‘the most extreme case’. Section 16 (2) provides that the maximum amount available which can only be awarded in the most extreme case is \$350,000.00. Section 16 (3) provides that the damages are to be reduced in accordance with a table, so that, for example, a claimant whose non-economic loss is 15% of the most extreme case will receive 1% of the maximum amount, and a claimant whose non-economic loss is 25% of the most extreme case will receive 6.5% of that amount. When the damages reach 33% and above then they are not reduced.

The *CLA* limits the damages for future economic loss.<sup>84</sup> The extent of the economic loss could be proved through the usual means, such as employment and taxation documentation.

### 17.10 Mental harm consequent to physical injury

Physical injury from a suicide attempt may also lead to mental harm,<sup>85</sup> for example more severe depression than that which subsisted prior to the suicide attempt. The *CLA* stipulates that there is no duty of care for mental harm unless the defendant ought to have foreseen that a person of ‘normal fortitude’ might, in the circumstances of the case, suffer a ‘recognised psychiatric illness’.<sup>86</sup> This applies to consequential mental harm,<sup>87</sup> which means ‘mental harm that is a consequence of personal injury of any other kind’.<sup>88</sup>

Depression is probably a recognised psychiatric illness within the meaning of the *CLA*.<sup>89</sup> Where mental harm is consequent upon other personal injury, the *CLA* provides that the circumstances of the case to be considered in determining whether a person of normal fortitude would suffer a recognised psychiatric illness also include ‘the personal injury suffered by the plaintiff’.<sup>90</sup>

The provisions of the *CLA* in relation to mental harm, and the meaning of ‘normal fortitude’, are considered further in Appendix A.<sup>91</sup> For present purposes it suffices to argue that physical injury could lead to depression in a person of normal fortitude: ‘it cannot be doubted that ... negligence which brings about a motor vehicle accident may ... cause injuries to the plaintiff which make him deeply depressed’.<sup>92</sup>

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<sup>84</sup>Section 12 (2) provides that the court is to ignore the amount, if any, by which the claimant’s weekly earnings would have exceeded three times the average weekly earnings. Section 13 (1) provides that a court cannot make an award of damages for future economic loss unless the claimant first satisfies the court that assumptions about future earning capacity accord with the claimant’s most likely future circumstances but for the injury. Section 13 (2) provides that when a court determines any amount for future economic loss the amount must be reduced by reference to the percentage possibility that the events might have occurred but for the injury.

<sup>85</sup>‘Mental harm’ is defined in section 27 (b) of the *CLA* as ‘impairment of a person’s mental condition’.

<sup>86</sup>Section 32 (1).

<sup>87</sup>Section 32 (1) and (3).

<sup>88</sup>Section 27.

<sup>89</sup>Section A.1.

<sup>90</sup>Section 32 (3).

<sup>91</sup>Section A.1.

<sup>92</sup>*NSW IMC* per Mahoney JA at 296.

A cleric who provides pastoral counselling for depression ought, it is submitted, foresee that physical injury could make a person of normal fortitude depressed, or more depressed. There is ‘an element of guesswork’ as to the meaning of some provisions of the *CLA*.<sup>93</sup> This applies to the meaning of ‘normal fortitude’ and ‘recognised psychiatric illness’, thus a definitive conclusion on these issues is not possible.

### **17.11 Economic loss consequent to consequential mental harm**

The *CLA* states that ‘a court cannot make an award of damages for economic loss for consequential mental harm resulting from negligence unless the harm consists of a recognised psychiatric illness’.<sup>94</sup> If depression is a recognised psychiatric illness then damages for economic loss caused by unnecessarily prolonged or exacerbated depression resulting from a suicide attempt would be recoverable. As a general proposition, depression could cause economic loss through loss of a job or poor academic performance.<sup>95</sup>

### **17.12 Assessment of damage**

If the breach of duty is proved to have caused the alleged damage, the quantum of the damages must be determined. Damages will be reduced to the proportion attributable to the breach of duty, and regarding assessment of damages, as opposed to causation, it is clear that both past and future hypothetical situations may be considered even though it is only possible, not probable that they would have eventuated:

Questions as to the future or hypothetical effect of physical injury or degeneration are not commonly susceptible of scientific demonstration or proof. If the law is to take account of future or hypothetical events in assessing damages, it can only do so in terms of the degree of probability of those events occurring ... where proof is necessarily unobtainable, it would be unfair to treat as certain a prediction which has a 51% probability of occurring, but to ignore altogether a prediction which has a 49% probability of occurring ... The approach is the same whether it is alleged that the event would have occurred before or might occur after the assessment of damages takes place.<sup>96</sup>

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<sup>93</sup> Dietrich, 18.

<sup>94</sup> Section 33.

<sup>95</sup> *NHMRC Guidelines*, 1.

<sup>96</sup> *Malec* per Deane, Gaudron & McHugh JJ at 643, similarly see Brennan & Dawson JJ at 639.

If, separately to depression and to any injury sustained in the suicide attempt, the plaintiff had another physical disability whether arising before or after the suicide attempt, which contributed to the such loss, that would be relevant.

A plaintiff who could only prove that partial or temporary recovery from depression would have taken place had referral occurred may still have been at risk of suicide subsequent to the date on which the suicide attempt was made.

In such a case the defendant might argue that the plaintiff would have remained at risk of suicide from depression subsequent to the date of the suicide attempt, even if referral was made, since there would have been some residual depression. If the defendant can prove this risk is more than 1%, the court will reduce the plaintiff's damages accordingly.<sup>97</sup>

In this regard, 50 - 85 % of those who suffer a single episode of major depressive disorder will have at least one more episode.<sup>98</sup> The lifetime risk of suicide of those with untreated depression is 20%.<sup>99</sup>

Allowing for the possibility of effective future treatment and for the fact that a future attempt might not occur until years later, the discount in damages to reflect the possibility of a suicide attempt from residual depression may only be a small percentage, the size of which would always depend on the facts.

However if there was evidence that the possibility of a future suicide attempt was merely speculative the Court would not reduce the plaintiff's damages to allow for such a possibility.<sup>100</sup>

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<sup>97</sup> *Ibid* per Deane, Gaudron & McHugh JJ at 643.

<sup>98</sup> *APA Guideline*, Part A, II, D.

<sup>99</sup> Beutler, Clarkin & Bongar, 303.

<sup>100</sup> For example in *Chappel* Gaudron, Gummow & Kirby JJ declined to reduce the plaintiff's damages to allow for the possibility that she may have later suffered harm of the kind that eventuated because the uncontroverted evidence was that this possibility was merely speculative - see Gaudron J at 242, Gummow J at 263, Kirby J at 277-278.

## Conclusion

The *CLA* provides a basis for considering causation. As it relates to causation, the intention of the *CLA* is to guide the courts as they apply an approach based on common sense. Consideration of causation remains complex, difficult and discretionary.

Plaintiffs would generally have considerable difficulty in proving that breach of the duty to refer was a necessary condition of a suicide attempt. However failure to establish that the breach of duty was a necessary condition would not preclude a finding of factual causation, as the *CLA* permits such a finding even where the breach is not a necessary condition of the harm if the case is 'exceptional'.

The *CLA* affords limited guidance as to what may constitute an exceptional case. While not conclusive of the issue, the *Review of the Law of Negligence* suggests that where a breach of duty makes a 'material contribution to risk' the case may fall within this exceptional category.

It could be argued that where a cleric provides pastoral counselling for depression and does not comply with the duty to refer, the cleric's conduct has increased the risk to the client, if the client has been diverted or delayed from using the main treatments for depression. Similarly if it is alleged that the cleric exacerbated the depression in some way which amounted to a breach of duty, it could be argued the risk to the client was increased. It could thus be argued that a breach of the duty to refer should be accepted as establishing factual causation even if it cannot be proved on the balance of probabilities to have been a necessary condition to the event.

The *CLA* further stipulates that causation will not be established unless it is appropriate for the scope of the negligent person's liability to extend to the harm so caused. This requirement subsumes the common law concept of remoteness of damage. The *CLA* directs attention to whether or not and why responsibility for the harm should be imposed on the negligent party.

If breach of the duty to refer is a necessary condition of the occurrence of a suicide attempt, or if it materially increased the risk, then it is arguably appropriate that the scope of liability extend to damage arising from the suicide attempt.

Examination of relevant authority of the Court, however, suggests that a suicide attempt will not break the causal chain between a failure to take reasonable care and injury arising from a suicide attempt where counselling for depression is being provided. This arguably supports the proposition that the Court would not hold that it is inappropriate that the scope of liability extend to damage from a suicide attempt.

The *CLA* provides in relation to contributory negligence that the standard of care required of the person who suffered harm is that of a reasonable person in the position of that person. It is arguable that this does not require a court to ignore the particular attributes of the plaintiff, nor the particular relationship between the plaintiff and defendant, and that a suicide attempt does not amount to contributory negligence under the *CLA* or at common law.

A suicide attempt may lead to physical, economic and / or mental harm. As discussed in this chapter the *CLA* has impacted on the assessment of damage.



In the next chapter the law and main issues relevant to whether a church could be liable for counselling negligence by a cleric will be examined.

## POSSIBLE LIABILITY OF CHURCHES

### Introduction

This chapter considers the law and main issues relevant to the possible liability of a church for the counselling negligence of a cleric. In practice a client bringing a claim against a cleric may also make a claim against the cleric's church.

The area is a particularly difficult one. Identification of a church's legal and ecclesiastical structures may be 'an extremely complex matter'.<sup>1</sup> Church governance and structure differ from church to church, thus 'unthinking application of the practices of one [religious] tradition to another' may lead to error.<sup>2</sup>

It would be useful, therefore, to examine the structure of a selected denomination, or two denominations, in detail. Such examination would almost require a thesis in itself, and is not possible herein. Accordingly it is not sought to apply the relevant law to a particular fact situation. Rather than omitting consideration of the potential liability of a church entirely though, this chapter has been included, as some such consideration may be better than none at all.

A claim for negligent counselling by a cleric is likely to be made against the cleric who provided the counselling; senior clergy such as bishops or archbishops; directors and voting members of the church, if any; relevant dioceses or synods; and property trusts.<sup>3</sup>

Some churches may have a centrally organised leadership structure, which may be conducive to imposition of vicarious liability. Other churches may not, for example the Congregational Churches Fellowship of New South Wales consists of a fellowship of a dozen or so local churches with 'no hierarchy'.<sup>4</sup>

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<sup>1</sup> Cf. *Residential Schools (Re)* (2001) 204 DLR (4th) 80 per McClung, Berger & Wittmann JJ.A at 83-84 (Alberta Court of Appeal).

<sup>2</sup> *Ermogenous v Greek Orthodox Church of SA Inc* (2002) 76 ALJR 465 per Gaudron, McHugh, Hayne & Callinan JJ at 467.

<sup>3</sup> Another issue is the apportionment of liability among the various defendants. This is beyond the scope of the thesis.

<sup>4</sup> Conversation by the author with Rev Steve Shooter, 03.08.01.

Similarly the Churches of Christ have only a 'small head office not involved with the day to day running of local churches'.<sup>5</sup> The Brethren are another church with no formal leadership structure.<sup>6</sup>

Alternatively the church may consist of only one building, one cleric and one congregation. In such instances vicarious liability will be difficult or impossible to establish, or there may simply be no other legal person apart from the defendant cleric.

Within a denominational structure there may be separate 'orders' or 'churches'. For example within the Catholic denomination there are various orders such as the Christian Brothers and the Good Samaritan Sisters, and no less than sixty-six other orders.<sup>7</sup>

The Presbyterians are grouped into at least three quite separate churches: the Presbyterian Church in New South Wales, the Presbyterian Church of Eastern Australia and the Presbyterian Reformed Church of Australia.<sup>8</sup> A verdict against one of these orders or churches would not mean liability of the others to meet the verdict.

In Australia all churches are treated in law as being voluntary associations.<sup>9</sup> It is not compulsory for churches to be incorporated. The governing bodies of some churches are empowered by legislation to declare that an unincorporated body of the church should be constituted as a corporation.<sup>10</sup>

Unincorporated churches will not have a distinct legal status from members comprising it.<sup>11</sup> Thus a plaintiff suing an unincorporated 'church' would need to join all members as defendants and seek damages against them personally.<sup>12</sup>

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<sup>5</sup> Conversation by the author with Ms Susan Hill 03.08.01.

<sup>6</sup> Fisher & MacFarlane, 38-39.

<sup>7</sup> *Sydney White Pages* 2001/02 A-K 557-559.

<sup>8</sup> *Ibid* L-Z 2434.

<sup>9</sup> Eg. *Scandrett* per Mahoney JA at 491.

<sup>10</sup> Eg. *Presbyterian Church (Corporations) Act 1995* (NSW) s. 7.

<sup>11</sup> Fisher & MacFarlane, 23.

<sup>12</sup> Cf *Cameron v Hogan* (1934) 51 CLR 358 per Rich, Dixon, Evatt & McTiernan JJ at 371: 'the difficulty of framing an action by one member of a large body of persons for damages for breach of a contract constituted by his admission to membership has always been very great. Such a contract apparently is considered joint, and in common law in strictness it would have been necessary for the plaintiff to join all the members as defendants ... If the members of the body were very numerous, it might well become too difficult for a defendant to succeed upon such a plea'.

Even where the plaintiff succeeds in establishing the liability of an entity other than the defendant cleric, enforcement of the verdict may prove difficult. This is because many of the assets of some churches are held by property trusts.<sup>13</sup>

In the case of the Uniting Church, for example, assets may be held in trust in favour of 'any one or more' of the Uniting Churches.<sup>14</sup> Thus if a plaintiff was to succeed in gaining access to assets held in favour of one local Uniting Church this would not mean access to the total assets held by the overall Uniting Church denomination.

Vicarious liability involves one person being held liable for the wrong of another, although free from personal legal fault.<sup>15</sup> For churches to be held vicariously liable for negligent counselling it is unnecessary that the negligence be authorised.<sup>16</sup>

Determination of whether a particular church is vicariously liable for a cleric's negligence requires consideration of the bases on which churches could be vicariously liable and the nature of the church-cleric relationship, undertaken in section 18.1.

The bases upon which a church could be liable also include breach of a duty of care owed directly to clients of clergy, breach of a non-delegable duty to ensure that clergy take reasonable care, and specific authorisation of a negligent act or omission. These bases are discussed in sections 18.2, 18.3 and 18.4 respectively.

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<sup>13</sup> See for example the *Anglican Church of Australia Trust Property Act 1917* (NSW); *Baptist Churches of New South Wales Property Trust Act 1984* (NSW); *Lutheran Church of Australia (New South Wales District) Property Trust Act 1982* (NSW); *Uniting Church in Australia Act 1977* (NSW).

<sup>14</sup> *Uniting Church in Australia Act* section 20 (9) (d).

<sup>15</sup> Fleming, 409.

<sup>16</sup> Cf. *Hollis v Vabu Pty Ltd* (2001) 75 ALJR 1356 at 1376 per McHugh J quoting approvingly a statement by Willes J in *Barwick v English Joint Stock Bank* (1867) LR 2 Ex 259 at 266: 'It may be said ... that the master has not authorised the act. It is true, he has not authorised the particular act, but he has put the agent in his place to do that class of acts'. Ordination does not mean clergy are authorised to counsel. Clergy are usually not authorised to do anything until licensed. A licence may or may not authorise counselling.

## 18.1 Bases of vicarious liability

A church will be vicariously liable for an employed cleric's negligent counselling if provision of it was within the course of the cleric's employment.<sup>17</sup> The circumstances in which clergy might be employees of churches are considered in section 18.1.1.

A person may be vicariously liable for the acts of an agent.<sup>18</sup> The circumstances in which the church-cleric relationship might be one of principal-agent are considered in section 18.1.2.

If a cleric is an independent contractor, their church will, in general, not be vicariously liable for their torts: 'it has long been accepted, as a general rule ... that a principal is not liable for the tortious acts of an independent contractor'.<sup>19</sup> An exception is where the independent contractor is an agent.<sup>20</sup>

The rationale for excluding liability for independent contractors is that the work the contractor has agreed to do is not done as the representative of the employer.<sup>21</sup> In section 18.1.3 it is suggested that the church-cleric relationship will not generally be one of principal and independent contractor.

The potential for imposition of vicarious liability on a church even where the cleric is not an employee or agent is discussed thereafter.

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<sup>17</sup> In New South Wales employers are vicariously liable for torts of employees committed in the course of employment, or directed to or incidental to the carrying on of any business enterprise, undertaking or activity of his employer - *Law Reform (Vicarious Liability) Act 1983 s. 7*.

<sup>18</sup> Eg. *Scott v Davis* (2000) 204 CLR 333 per McHugh J at 353; *Colonial Mutual Life Assurance Society Ltd v Producers and Citizens Co-operative Assurance Co of Australia Ltd* (1931) 46 CLR 41; Trindade & Cane, 733. Strictly speaking the principal is liable directly as principal as opposed to vicariously, however this distinction has been treated as of little practical significance by the case law - see Dal Pont, G.E. 2001 *Law of Agency* Butterworths, Australia, 594.

<sup>19</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1363.

<sup>20</sup> *Colonial Mutual Life Assurance Society Ltd* per Dixon J at 48-49.

<sup>21</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1365.

### 18.1.1 Whether clergy are employed by churches

A church may be an employer.<sup>22</sup> The Court considered whether a cleric may be an employee of a church in *Ermogenous v Greek Orthodox Community of SA Inc*,<sup>23</sup> holding that a contract of employment may exist between churches and clergy:

To say that a minister of religion serves God and those to whom he or she ministers may be right, but that is a description of the minister's spiritual duties. It leaves open the possibility that the minister has been engaged to do this under a contract of employment.<sup>24</sup>

In the past, Australian, English and New Zealand courts have been reluctant to hold that contracts exist between churches and clergy, because of the spiritual nature of clergy duties.

The main stumbling block for clergy seeking to prove existence of an employment contract (with a view to securing enforcement of wages, for example) has been perceived lack of intent to create legal relations on the part of the parties.<sup>25</sup>

The joint judgment in *Ermogenous* indicated there is no presumption that agreements between churches and clergy are not intended to be legally enforced: 'we doubt the utility of using the language of presumptions in this context'.<sup>26</sup> Similarly Kirby J stated:

A minister of religion must be housed, must eat, be clothed and otherwise provided for. The fact that his or her vocation is, at one level, spiritual in purpose and character does not, of itself, remove the possibility that arrangements for necessities may have been intended to be enforced when it is proved that such arrangements have been breached.<sup>27</sup>

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<sup>22</sup> See eg. Fisher & MacFarlane, 141-142.

<sup>23</sup> (2002) 76 ALJR 465.

<sup>24</sup> *Ermogenous* per Gaudron, McHugh, Hayne & Callinan JJ at 474; similarly see Kirby J at 478.

<sup>25</sup> See eg. *Knowles v Anglican Church Property Trust* (1999) 89 IR 47; *In re Employment of Church of England Curates* [1912] 2 CH. 563; *Rogers v Booth* [1937] 2 All ER 751; *President of the Methodist Conference v Parfitt* [1984] 1 QB 368; *Davies v Presbyterian Church of Wales* [1986] 1 WL 323; *Diocese of Southwark v Coker* [1998] ICR 140; *Mabon v Conference of the Methodist Church of New Zealand* [1998] 3 NZLR 513.

<sup>26</sup> *Ermogenous* per Gaudron, McHugh, Hayne & Callinan JJ at 471.

<sup>27</sup> *Ibid* per Kirby J at 479.

In determining whether a contract exists basic principles of contract law apply.<sup>28</sup> Whether an intention to create legal relations exists will depend on the circumstances:

The circumstances which might properly be taken into account in deciding whether there was the relevant intention are so varied as to preclude the formulation of any prescriptive rules ... the word “intention” describes ... what would objectively be conveyed by what was said or done, having regard to the circumstances in which those statements and actions happened. It is not a search for the uncommunicated subjective motives or intentions of the parties.<sup>29</sup>

There can be no automatic translation of previous cases to future cases because matters of church governance and structure differ from church to church.<sup>30</sup> If the relationship between churches and clergy is contractual it will be necessary to determine whether the contract is one of employment. This issue is now considered.

### **18.1.2 The test for employment**

The ‘test’ for employment has been considered by the Court in numerous cases.<sup>31</sup> A multi-factorial approach has been taken, which has been described elsewhere.<sup>32</sup> The case of most relevance is the decision of the Court in *Hollis*, which concerned the liability of a courier company for torts of bicycle couriers.

Gleeson CJ, Gaudron, Gummow, Kirby and Hayne JJ held that an employment relationship existed, referring to factors including the following: the bicycle couriers were not running their own enterprise; they did not have independence in their work or hours of work; the defendant had the right and ability to control the couriers; the couriers were presented to the public as emanations of the defendant; if vicarious liability was not imposed victims of the couriers would likely be without redress and the defendant would have no incentive to discipline couriers found guilty of wrongdoing; the defendant provided insurance for the couriers and superintended their finances; and there was limited scope for the couriers to pursue their own business enterprise.<sup>33</sup>

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<sup>28</sup> *Ibid* per Gaudron, McHugh, Hayne & Callinan JJ at 472.

<sup>29</sup> *Ibid* 471.

<sup>30</sup> *Ibid* 472.

<sup>31</sup> Eg. *Stevens v Brodribb Sawmilling Co Pty Ltd* (1986) 160 CLR 16; *Zuijs v Wirth Brothers Pty Ltd* (1955) 93 CLR 561 and *Federal Commissioner of Taxation v Barrett* (1973) 129 CLR 396.

<sup>32</sup> Eg. Fleming, 413-420.

<sup>33</sup> At 1366-1368. The Court has previously indicated that other potentially relevant factors include the mode of remuneration, provision for holidays, the deduction of income tax from wages, the right to have a particular person do the work, the right to

The joint judgment also indicated that ‘in general, under contemporary Australian conditions, the conduct by the defendant of an enterprise in which persons are identified as representing that enterprise should carry an obligation to third persons to bear the cost of injury or damage to them which may fairly be said to be characteristic of the conduct of that enterprise’.<sup>34</sup>

### **18.1.3 General considerations in applying the test for employment to clergy**

Whether a cleric is an employee of a church will vary from case to case. Some general observations can be made, however. The terms of any contract will always be of considerable importance.<sup>35</sup> In each case the totality of the relationship between the parties must be considered.<sup>36</sup>

#### **18.1.3.1 Labelling of the relationship is not conclusive**

Parties cannot deem their relationship to be something it is not,<sup>37</sup> thus labelling clergy as employees does not make them employees, nor will describing them as non-employees preclude employment. In *Knowles* the minister relied upon a letter of appointment which referred to his ‘employment’ as chaplain, however the court found that the word employment had been used in a ‘loose sense’ and was of ‘limited’ significance.<sup>38</sup>

#### **18.1.3.2 Ordination**

It has been held in England that ordination does not itself create a contract between clergy and the ordaining church<sup>39</sup> nor does becoming a practising minister create a contract.<sup>40</sup> These propositions are consistent with Australian contract law.

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suspend or dismiss the person engaged, the right to the exclusive services of the person engaged, and whether saleable assets or goodwill were created in the course of the work - see for example *Stevens* per Mason J at 24, per Wilson & Dawson JJ at 36-37.

<sup>34</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1365.

<sup>35</sup> Cf. *Stevens* per Wilson & Dawson JJ at 37.

<sup>36</sup> Cf. *Stevens* per Mason J at 29.

<sup>37</sup> See eg. *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1368.

<sup>38</sup> *Knowles* per Wright J at 90-91.

<sup>39</sup> *Id.*

<sup>40</sup> *Ibid* 376.

### **18.1.3.3 Treatment of clergy for taxation purposes**

Treatment of clergy as employees for tax purposes is not decisive.<sup>41</sup> Churches have successfully argued that these arrangements are of limited significance because they are made only for convenience or to comply with tax laws, or that ministers are paid not for their services, but to provide for their material needs.<sup>42</sup>

### **18.1.3.4 Control**

The ability of the 'employer' to control the worker has been regarded as important in determining the employment status of workers.<sup>43</sup> However 'control' is only one relevant factor.<sup>44</sup> Thus even if a church cannot 'control' a cleric, this will not preclude the existence of an employment relationship.<sup>45</sup> The extent to which 'senior' clergy within a church have control over a particular cleric will vary from case to case.

### **18.1.3.5 Difficulty identifying persons in control**

Plaintiffs seeking to show that clergy are church employees will face the added difficulty that different legal persons forming the one denominational structure may be responsible for different dealings with the cleric. For example the person or entity which pays the cleric may not be the one controlling the cleric.<sup>46</sup> This will create further difficulty in identifying all appropriate defendants.<sup>47</sup>

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<sup>41</sup> See *Knowles* per Wright J at 89, *Mabon* per Richardson P at 526.

<sup>42</sup> See eg. *Parfitt* per Dillon LJ at 375, *Donaldson* MR agreeing.

<sup>43</sup> Eg. *Stevens* per Mason J at 24.

<sup>44</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1366.

<sup>45</sup> *Ermogenous* per Kirby J at 482. In *Knowles* the church argued that 'once a clergy person has been licensed to perform their ministerial activities ... the bishop has no capacity to direct the clergy in the performance of their duties' - at 56. On the other hand the minister argued that he was part of a highly regulated and administered organisation, and this was partly conceded by the church - at 69.

<sup>46</sup> See eg. *Knowles* at 68-69.

<sup>47</sup> See *Ermogenous* per Gaudron, McHugh, Hayne & Callinan JJ at 473.

### **18.1.3.6 Church structure**

If incorporated a church can sue and be sued.<sup>48</sup> The power to manage a company's affairs is vested in the board of directors, usually to the exclusion of members. When *Ermogenous* was before the Industrial Relations Court of South Australia Parsons J said that Archbishop Ermogenous' position 'may be likened to a director of a company who may also be an employee of the company'.<sup>49</sup>

### **18.1.3.7 The right to suspend or dismiss clergy**

Some churches have a right to suspend or dismiss clergy.<sup>50</sup> The threat of such a right being exercised may be one of the best ways to exert control. However in practice the rules and appeals procedures in relation to removal of clergy may be so complicated that those involved in the management of a church wishing to remove a cleric would decide to let a cleric remain in their position rather than precipitate a lengthy dispute.

### **18.1.3.8 The course of employment**

If an employment relationship is held to have existed, whether the counselling in question was 'in the course of employment' will also depend on the facts, particularly the terms of any written contract. The main issue is whether the employee performed an authorised task the wrong way, in which case the wrongful act will still be within the course of employment, (even if the employer's instructions as to how to perform the task were disregarded) or embarked on a completely different task.<sup>51</sup>

Thus if provision of counselling for depression was authorised, any counselling for depression will be within the course of employment. However authorisation may not be so specific; then it will be necessary to examine all the facts.

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<sup>48</sup> *Corporations Act 2001* s. 124(1); *Associations Incorporation Act 1984* (NSW) section 15. Where churches incorporate, they commonly become a company limited by guarantee - Fisher & MacFarlane, 35.

<sup>49</sup> *Greek Orthodox Community of SA Inc v Ermogenous* (1999) 89 IR 188 per Parsons J at 198.

<sup>50</sup> For example in relation to the Anglican Church 'Once ordained clergy are subject to the discipline of the Church ... administered in the first instance through the bishop of the diocese ... [the discipline] could lead to removal of the parson's orders.' - *Knowles* at 57.

<sup>51</sup> See eg. Fleming, 421: 'the course of employment is said to encompass such unauthorised acts by the servant as can be regarded wrongful and unauthorised *modes* of performing an authorised task ... But the limit is exceeded when, instead of acting in furtherance of the assigned task, the servant indulges in an unrelated and independent venture of his own'.

## 18.1.2 Are clergy agents of churches?

If a cleric is not an employee, whether the cleric was an agent of the church is relevant. Difficulties arise from the many senses in which the word agent is employed.<sup>52</sup> Gleeson CJ explained:

The protean nature of the concept of agency ... bedevils this area of discourse ... to describe a person as the agent of another, in this context, is to express a conclusion that vicarious liability exists, rather than to state a reason for such a conclusion.<sup>53</sup>

Explanation of the meaning of 'agent' is given by Dal Pont:

The narrowest legal definition of 'agent' connotes 'an authority or capacity in one person to *create* legal relations between a person occupying the position of principal and third parties'. A broader conception of agency covers 'a person who is able, by virtue of the authority conferred upon him, to create *or affect* legal rights and duties as between another person, who is called his principal, and third parties. Wider again is the characterisation of an agent as 'a person who has authority *to act* on behalf of a principal, either generally or in respect of some particular act or matter'.<sup>54</sup> (emphasis in original)

The first of these definitions would apply if the cleric who provides counselling for depression is authorised by their church to enter into contracts on their church's behalf and does so with a client regarding counselling for depression. In that case any liability of the church will be in contract not negligence, and the liability will not be vicarious. In general the third of those definitions would appear of most relevance to clergy, however: in the law of negligence the term 'agent' is used to indicate that one person acts with the authority of another.<sup>55</sup> A principal is liable for the acts of an agent acting as the representative of the principal and within the scope of his or her authority, whether or not those acts were specifically authorised.<sup>56</sup>

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<sup>52</sup> *Scott* per McHugh J at 349, per Gummow J at 410.

<sup>53</sup> *Ibid* per Gleeson CJ at 338-339.

<sup>54</sup> Dal Pont, G.E. 2001 *Law of Agency* Butterworths, Australia, 5, footnotes omitted.

<sup>55</sup> Trindade & Cane, 732.

<sup>56</sup> *Scott* per McHugh J at 366-367.

### 18.1.3 Are clergy independent contractors?

The difference between an employee and an independent contractor is as follows:

The distinction between an employee and an independent contractor is rooted fundamentally in the difference between a person who serves his employer in ... the employer's business, and a person who carries on a trade or business of his own.<sup>57</sup>

Applying this to clergy, the calling of clergy is not distinct from the mission of their church. Their work is not merely for their own benefit. They are not 'carrying on a trade or business of their own'. They are generally trained, ordained and licensed by their church.

Where clergy do not engage in other vocations, in addition to being clergy, they are even less independent of churches. While many clergy may have some autonomy in their day to day ministries, there appears to be, in general, little scope to conclude that clergy are independent contractors.

If neither an employment nor an agency relationship can be established between churches and clergy, a plaintiff might try to establish some other basis of vicarious liability.

Before commenting on what approach the Court might take in determining whether a church could be vicariously liable for the counselling negligence of a cleric in the absence of an employment or agency relationship, it is useful to consider in the next section an approach taken by Dillon J of the British Columbia Supreme Court.

The case concerned is the unreported one of *Mowatt v Clarke, The Anglican Church of Canada, The General Synod of the Anglican Church of Canada, The Anglican Diocese of Cariboo, The Synod of the Diocese of Cariboo, and Her Majesty the Queen in Right of Canada*.<sup>58</sup>

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<sup>57</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1365.

<sup>58</sup> The author thanks his Principal Supervisor for supplying a copy of the substantive judgment. The defendants did not appeal the decision by Dillon J. *Mowatt* was the first of many cases which have come before Canadian courts dealing with the sexual abuse of aboriginal children in residential schools - see *Mowatt* per Dillon J (judgment on costs, paragraph 6; <http://www.canlii.org/bc/cas/bcsc>).

#### 18.1.4 *Mowatt v Clarke and others*

In *Mowatt* Dillon J, sitting alone, drew from Canadian authority involving an employer's liability for sexual abuse by employees. In particular, Dillon J referred to *Bazley v Curry* in which McLachlin J, delivering the judgment of the Supreme Court of Canada stated:

The idea that a person who introduces a risk incurs a duty to those who may be injured lies at the heart of tort of law ... This principle of fairness applies to the issue of vicarious liability ... This policy interest embraces a number of subsidiary goals. The first is the goal of effective compensation ... However, effective compensation must also be fair ... Vicarious liability is arguably fair in this sense. The employer puts in the community an enterprise which carries with it certain risks. When those risks materialise and cause injury to a member of the public despite the employer's reasonable efforts, it is fair that the person or organisation that creates the enterprise and hence the risk should bear the loss.<sup>59</sup>

Dillon J focussed on a defendant's 'enhancement of a risk' to the plaintiff as a matter supporting imposition of vicarious liability, expressing the view that courts should:

Openly confront the question of whether liability should lie against the employer, rather than obscuring the decision beneath semantic discussions ... vicarious liability is generally appropriate where there is a sufficient connection between the creation or enhancement of a risk and a wrong that accrues therefrom.<sup>60</sup>

Dillon J emphasised that because the church defendants had placed Clarke in a position where he assumed 24 hour care of children, in circumstances where his bedroom was immediately adjacent to their dormitory, and failed to supervise Clarke, they had increased the risk to the children, of whom the plaintiff was one. It was therefore appropriate that the defendants be held vicariously liable, even though the sexual abuse had not been authorised, and was completely contrary to the defendants' wishes.<sup>61</sup>

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<sup>59</sup> [1999] 2 SCR 534 at 545.

<sup>60</sup> *Mowatt* per Dillon J at paragraph 128.

<sup>61</sup> See paragraph 140.

### 18.1.5 Vicarious liability in the absence of an employment or agency relationship

‘The principle of “vicarious” liability does not rest upon “agency” in its proper sense, nor simply on the employment relationship’,<sup>62</sup> but rather has its basis in policy:

The modern doctrine respecting the liability of an employer for the torts of an employee was adopted not by way of an exercise in analytical jurisprudence but as a matter of policy.<sup>63</sup>

The doctrine of vicarious liability continues to be guided by policies:

Not only does the doctrine of vicarious liability have its basis in policy considerations, but common law courts acknowledge that the evolution of the doctrine continues to be guided by policy.<sup>64</sup>

According to McHugh J, two policies are fundamental:

[T]he two fundamental policy concerns that underlie vicarious liability are (1) the provision of a just and practical remedy for harm; and (2) the deterrence of future harm.<sup>65</sup>

Gleeson CJ, Gaudron, Gummow, Kirby and Hayne JJ also adverted to the policy of deterring harm in *Hollis*, quoting from the judgment of McLachlin J in *Bazley v Curry*:

Beyond the narrow band of employer conduct that attracts direct liability in negligence lies a vast area where imaginative and efficient administration and supervision can reduce the risk that the employer has introduced into the community. Holding the employer vicariously liable for the wrongs of its employee may encourage the employer to take such steps, and hence, reduce the risk of future harm. A related consideration raised by Fleming is that by holding the employer liable, ‘the law furnishes an incentive to discipline servants guilty of wrongdoing’.<sup>66</sup>

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<sup>62</sup> *Scott* per Gummow J at 413.

<sup>63</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1364. Similarly see *Hollis* per McHugh J at 1374. See further *Scott* per Gummow J at 409: ‘the common law derived the notion of vicarious liability from medieval notions of headship of a household, whereby the legal standing of wives and servants was absorbed into that of the master’.

<sup>64</sup> *Ibid* per McHugh J at 1374.

<sup>65</sup> *Ibid* per McHugh J at 1374-1375.

<sup>66</sup> *Ibid* 1367; *Bazley* at 554-555.

There is, however, no satisfactory basis for vicarious liability:

[T]he absence of a satisfactory and comprehensive jurisprudential basis for the imposition of liability on a person for the harmful acts of others - vicarious liability, as it is called - is a matter which has provoked much comment. It may be that the lack of a satisfactory jurisprudential basis is referable, at least in significant part, to the fact that certain cases have been decided by reference to policy considerations without acknowledgment of that fact.<sup>67</sup>

It is therefore difficult to predict whether and on what basis the Court would hold a church vicariously liable if an employment or agency relationship did not exist. As already noted,<sup>68</sup> in *Hollis* the joint judgment stated:

In general, under contemporary Australian conditions, the conduct by the defendant of an enterprise in which persons are identified as representing that enterprise should carry an obligation to third persons to bear the cost of injury or damage to them which may fairly be said to be characteristic of the conduct of that enterprise.<sup>69</sup>

This statement was not intended to be a new basis of vicarious liability. This is clear from the fact that the majority went on to determine whether the courier was an employee.

Nonetheless it perhaps approximates an underlying rationale for vicarious liability. This may suggest that were a relevant case to arise where no employment or agency relationship existed, the Court would consider whether clergy were identified as representing their church, and whether the counselling was characteristic of the conduct of the enterprise of the cleric's church.

Clergy are often identified to the public as representing their church. Whether provision of pastoral counselling for depression is characteristic of the enterprise of churches will vary from church to church.

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<sup>67</sup> *New South Wales v Lepore* (2003) 212 CLR 511 per Gaudron J at 553.

<sup>68</sup> In section 18.1.2.

<sup>69</sup> *Hollis* per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1365.

Whether provision of counselling for depression is the main activity would not be definitive, as the Court has not said that an activity must be the main activity conducted by an enterprise in order to be characteristic of the enterprise.

The Court might also consider whether a defendant church had increased the risk to the plaintiff, as Dillon J did in *Mowatt*. It could be argued that ordination bestows on clergy the status that may induce a client to rely on their counselling. By allowing clergy to function as clergy, churches put clergy in a position, or location (within a church building) where people may turn to them.

Thus by ordaining clergy and allowing them to function as clergy, churches may increase the risk to clients of clergy, in the sense that clients may be diverted or delayed from using the main treatments for depression if reasonable care is not exercised.

Therefore in determining whether a church would be vicariously liable for a cleric's breach of duty the Court might consider whether the church had increased the risk to the plaintiff, whether the cleric had been ordained by the church, and whether the cleric was identified as a representative of the church.

The Court may also consider whether the type of counselling in question was an activity characteristic of the church's enterprise, whether the cleric was authorised by their church to provide the type of counselling for depression, and the extent to which the church had control over the cleric.

The recent case of *New South Wales v Lepore*,<sup>70</sup> is of limited assistance, as it concerned whether an educational authority was liable for the intentional criminal act of an *employed* teacher and the judgments did not deal significantly with the circumstances in which vicarious liability arises.

If no basis for vicarious liability can be established, a plaintiff would seek to show that a church owed him or her a duty of care directly. This basis of liability is considered in the next section.

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<sup>70</sup>(2003) 212 CLR 511.

## 18.2 Duty of care

As it is not possible to consider the issue of whether a church owes a direct duty of care to a client by examining the structures of a denomination in detail, some brief general comments will be made.

First, apart from the defendant cleric, other possible defendants will probably never have met the client. This may make it less likely that the client would rely on such personnel, however 'reliance is not always an essential ingredient for the plaintiff in a negligence case'.<sup>71</sup>

Second, depending on their precise position within the church, they may have knowledge or be expected to have knowledge or foresight of the characteristics and vulnerabilities of depressed clients generally, and of the fact that if a client were to rely on pastoral counselling for depression they may become more vulnerable.

Third, the rules and structure of a church may prevent the exercise of control over the cleric who provided the counselling, whereas other possible defendants might be viewed by those receiving pastoral counselling for depression as being in control of the counselling activities of clergy, and relied upon to do so.

Fourth, the primary elements of the degree of care required of other possible defendants would be likely to involve ensuring that clergy who provide pastoral counselling for depression had adequate knowledge to discharge their own duty of care, and in particular ensuring that clergy were aware of their obligation to comply with the duty to refer.

If a direct duty was owed by the church and a plaintiff failed to prove breach of the direct duty or vicarious liability, the plaintiff might argue that the duty was non-delegable. This would mean that even if the church took reasonable care in the training of clergy for counselling the church could still be liable for counselling negligence. Non-delegable duty is considered in the next section.

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<sup>71</sup> *Pyrenees* per Gummow J at 385.

### 18.3 Non-delegable duty

‘In order that there be a non-delegable duty of care there must first be a duty of care’.<sup>72</sup> Churches probably have no duty in respect of counselling unless they authorise or permit clergy to counsel. There is therefore probably no pre-existing duty of care.<sup>73</sup>

If clergy provide counselling it could be argued that churches owe a duty of care to clients. However that is a different duty to the duty owed by counsellors to exercise reasonable care when counselling. Therefore discussion of the non-delegable duty of churches regarding provision of counselling by clergy may be inapposite.

Assuming there is some scope for the duty owed by churches to clients of clergy to be non-delegable, it remains to consider whether it is non-delegable. In *Kondis v STA Mason J* said that non-delegable duty will arise where:

[T]he person on whom it is imposed has undertaken the case, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised.<sup>74</sup>

In *Burnie Port Authority v General Jones Pty Ltd* five judges of the Court made a further attempt to define the concept of non-delegable duty:

It will be convenient to refer to the [common element in relationships giving rise to non-delegable duty] as “the central element of control”. Viewed from the perspective of the person to whom the duty is owed, the relationship of proximity giving rise to the non-delegable duty of care in such cases is marked by special dependence or vulnerability on the part of that person.<sup>75</sup>

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<sup>72</sup> *Hollis* at per Gleeson CJ, Gaudron, Gummow, Kirby & Hayne JJ at 1362.

<sup>73</sup> This contrasts with employers, who have a non-delegable duty to employees to provide safe work systems, and hospitals, which have a non-delegable duty to patients (see further in this section). That duty pre-exists any delegation of the duty to other employees or doctors.

<sup>74</sup> (1984) 154 CLR 672 per Mason J at 687, Deane & Dawson JJ agreeing.

<sup>75</sup> (1994) 179 CLR 520 per Mason CJ, Deane, Dawson, Toohey and Gaudron JJ at 550-551.

In *Kondis* Mason J identified parties on whom a non-delegable duty has been imposed: hospitals, school authorities, employers and those sharing an adjoining wall.<sup>76</sup> The circumstances leading to imposition of a non-delegable duty are, however, unclear:

Judges and commentators have admitted that it is not always easy to identify the boundaries of the categories of non-delegable duty. Various criteria are nominated ... they do not define with precision the circumstances where the special duty will be imposed by law.<sup>77</sup>

As well as being unclear, the circumstances warranting imposition of non-delegable duty are similar to those warranting imposition of a delegable duty. In this regard Gummow J has observed that many cases not decided on the basis of non-delegable duty may have also answered the criteria for imposition of non-delegable duty identified by Mason J in *Kondis*.<sup>78</sup>

*Lepore* does not shed light on the circumstances in which a non-delegable duty will arise, since in that case a non-delegable duty plainly existed as a school authority was involved. A further difficulty with the concept of non-delegable duty is that it:

Departs from the basic principles of liability in negligence by substituting for the duty to take reasonable care a more stringent duty, a duty to ensure that all reasonable care is taken.<sup>79</sup>

Members of the Court have accordingly expressed reluctance to extend the range of non-delegable duties, for example:

The courts should be very cautious about extending the range of non-delegable duties, the law of which has already developed in a not entirely satisfactory and principled way.<sup>80</sup>

Some caution is required because the characterisation of a duty as non-delegable involves, in effect, the imposition of strict liability upon the defendant who owes that duty.<sup>81</sup>

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<sup>76</sup> At 679-681.

<sup>77</sup> *Northern Sandblasting* per Kirby J at 395. See also *Scott* per Gummow J at 417: 'How ... does the court decide a fresh case when the preferred criteria are historically descriptive but not normatively predictive?'

<sup>78</sup> *Scott* per Gummow J at 417. Similarly see *Northern Sandblasting* per Brennan CJ at 332: 'it is not easy to distinguish between the circumstances which give rise to a duty that is discharged by the selection of a competent independent contractor to undertake a particular task and the circumstances which give rise to a duty that can be discharged only by the non-negligent performance of the task'.

<sup>79</sup> *Kondis* per Mason J at 686.

<sup>80</sup> *Jones* per Callinan J at 49.

<sup>81</sup> *Scott* per Gummow J at 417.

Having regard to the above, prediction of whether a particular church is likely to owe a non-delegable duty to clients or particular types of clients is difficult. Resolution of this issue must await directly relevant authority.

The issue may boil down to the question of whether the dependence, if any, on a church by a client of a cleric is as 'special' as the dependence of hospital patients on hospitals, employees on employers to provide a safe system of work, school pupils on school authorities, and of those sharing an adjoining wall on each other not to employ a shoddy builder to effect renovations.

The *CLA* provides that if a plaintiff can establish the existence of a non-delegable duty this will not be of greater advantage to him or her than if vicarious liability is established:

The extent of liability in tort of a person ... for breach of a non-delegable duty to ensure that reasonable care is taken by a person in the carrying out of any work or task delegated or otherwise entrusted to the person by the defendant is to be determined as if the liability were the vicarious liability of the defendant for the negligence of the person in connection with the performance of the task.<sup>82</sup>

#### **18.4 Specific authorisation of counselling negligence**

A 'church' will be liable for negligent acts or omissions which the church itself authorises, regardless of the status of the cleric in question, and no principle of vicarious liability is needed in such cases:-

Whenever one person orders another to commit a tort, say an assault, he is liable just as if he had committed it himself, and it matters nothing whether it is perpetrated through the instrumentality of a servant, an "agent" , or a fierce dog. Here, truly, "qui facit per alium facit per se" [those who act through another are deemed to act in person].<sup>83</sup>

Thus if a church specifically instructs clergy to counsel for depression, for example, only in accordance with a religious text, specific authorisation of negligence will exist. This basis of liability would really involve breach of a duty of care owed by a church directly to a client, if one existed in a particular case, as discussed in section 18.2.

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<sup>82</sup>Section 5Q(1).

<sup>83</sup>Fleming, 412.

## **Conclusion**

This chapter considered the law and main issues relevant to the possible liability of a church for the counselling negligence of a cleric. It was not sought to apply the relevant law to a particular fact situation, as matters of church governance and structure differ from church to church and it would almost require a thesis in itself to examine the structures of a selected denomination in detail.

For churches to be held vicariously liable for negligent counselling it is unnecessary that negligence is authorised. A church will be vicariously liable for an employed cleric's negligent counselling if provision of it was within the course of the cleric's employment. A person may be vicariously liable for the acts of an agent. A principal is liable for the acts of an agent acting as the representative of the principal and within the scope of his or her authority, whether or not those acts were specifically authorised.

If a cleric is an independent contractor, their church will, in general, not be vicariously liable for their torts. An exception is where the independent contractor is an agent.

A church may be an employer. The Court has made it clear that there is no principle that there cannot be a contract of employment between churches and clergy.

However Courts have been reluctant to hold that contracts exist between churches and clergy, because of the spiritual nature of clergy duties and a perceived lack of intent to create legal relations on the part of the parties. In determining whether a contract exists basic principles of contract law should be applied. As to whether intent to create legal relations exists, this will depend on all the circumstances.

Whether a cleric is an employee of a church will thus vary from case to case. The terms of any contract will always be of importance. Labelling clergy as employees does not make them employees, nor will describing them as non-employees preclude employment. Treatment of clergy as employees for tax purposes is not decisive. Ordination does not itself create a contract between clergy and the ordaining church nor does becoming a practising minister create a contract.

The ability of the 'employer' to control the worker has been regarded as important in determining the employment status of workers. However 'control' is only one relevant factor. Thus even where a church cannot control a cleric, this may not preclude the existence of an employment relationship.

If an employment relationship is held to have existed, whether the counselling in question was 'in the course of employment' will also depend on the facts, particularly the terms of any written contract.

The main issue is whether the employee performed an authorised task the wrong way, in which case the wrongful act will still be within the course of employment, even if the employer's instructions as to how to perform the task were disregarded, or whether the employee embarked on a completely different task. Thus if counselling for depression was authorised, it will be within the course of employment. Where it is unauthorised, it will be necessary to examine the facts.

If a cleric is held not to be an employee, whether the cleric was an agent of the church will be relevant. Difficulties arise from the many senses in which the protean concept of agency is employed, and plaintiffs may have difficulty in proving that clergy were the agents of churches in respect of counselling for depression.

The concept of vicarious liability does not only rest upon an agency or employment relationship. However it is difficult to predict whether and why the Court would hold a church vicariously liable in the absence of an employment or agency relationship.

If no basis for vicarious liability can be established, a plaintiff would seek to show that a church owed him or her a duty of care directly. The duties of possible defendants apart from the cleric who provided the counselling will depend on the facts of each case. More specific comment could be made if the structures of individual denominations were examined in detail, however this is not possible herein.

The concept of non-delegable duty is another indeterminate area of negligence law. The circumstances leading to imposition of non-delegable duty are unclear. The lack of clarity in the authorities renders prediction of the non-delegability or otherwise of the duty owed by a church to a client of a cleric difficult.

A church will be liable for negligent acts or omissions which the church itself authorises, regardless of the status of the cleric in question, and no principle of vicarious liability is needed in such cases.

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In the next and final chapter some general conclusions are indicated.

## GENERAL CONCLUSIONS

### 19.1 Duty of care

The thesis sought to identify an approach to be taken in determining whether clergy owe a duty of care for pastoral counselling for depression.<sup>1</sup> The law of negligence in Australia contains ‘endemic difficulties’<sup>2</sup> and is of ‘inherent indeterminacy’.<sup>3</sup> There is no majority accepted general approach regarding duty of care,<sup>4</sup> and no directly relevant Australian case.

The law of negligence develops by reference to principles of general application.<sup>5</sup> Where a novel case arises, the existence of a duty can only be determined by reference to principles of general application,<sup>6</sup> and attention to the facts of the particular case.<sup>7</sup>

Few principles of general application can be found in the duty cases.<sup>8</sup> ‘Developments in the law of negligence over the last 30 or more years reveal the difficulty of identifying unifying principles that would allow ready solution of novel problems’.<sup>9</sup>

Reasons for avoiding an approach based on consideration of the degree of analogy between clergy and mental health professionals have been given.<sup>10</sup>

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<sup>1</sup> In relation to harm other than pure mental harm. Mental harm consequent upon personal injury from a suicide attempt was dealt with in section 17.10. Pure mental harm is mental harm not consequent upon other person injury - section 27 of the *CLA*. Comprehensive consideration of a duty of care for pure mental harm is beyond the scope of the thesis. Some discussion of the issue is included in Appendix A.

<sup>2</sup> *Scott* per Gummow J at 421.

<sup>3</sup> *Ibid* 422.

<sup>4</sup> *Perre* per McHugh J at 210; *Hill v Van Erp* (1997) 188 CLR 159 per Gummow J at 230; *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1578.

<sup>5</sup> *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1579.

<sup>6</sup> *Crimmins* per McHugh J at 34.

<sup>7</sup> Section 6.3.

<sup>8</sup> *Crimmins* per McHugh J at 34.

<sup>9</sup> *Sullivan* per Gleeson CJ, Gaudron, McHugh, Hayne & Callinan JJ at 1579.

<sup>10</sup> Section 7.2.

It is a general principle of the law of negligence that a duty of care will not arise unless the defendant can reasonably foresee harm to the plaintiff as a consequence of an act or omission by the defendant.<sup>11</sup>

Provision of pastoral counselling for depression is closely analogous to provision of advice or information.<sup>12</sup> In *MLC* Barwick CJ considered the features of the relationship in which a duty of care will arise for provision of advice information.<sup>13</sup>

The Court has accepted Barwick CJ's approach,<sup>14</sup> which was not confined to advice or information provided in business or professional contexts.<sup>15</sup> Nor was it confined to cases involving purely economic loss.<sup>16</sup>

It is of general relevance, applying where the advice or information is given in connection with some matter of serious consequence, whether a matter of business or not.<sup>17</sup> Depression is a matter of serious consequence. A case involving pastoral counselling for depression is one in which the approach of Barwick CJ in *MLC* should arguably be applied.

Questions of whether the speaker knew or should have known that the recipient of the information or advice intended or was likely to rely on it, and whether such reliance would be reasonable are central to that approach.<sup>18</sup> Barwick CJ emphasised that those questions are to be answered with regard to all the circumstances of the case.

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<sup>11</sup>Chapter eleven.

<sup>12</sup>Section 7.2.

<sup>13</sup>*MLC* at 571.

<sup>14</sup>Section 7.1.

<sup>15</sup>Section 7.2.

<sup>16</sup>Section 7.2.

<sup>17</sup>Section 7.2.

<sup>18</sup>Section 7.3.

‘Reliance’ as a factor which will favour the existence of a duty of care in the context of pastoral counselling for depression is not actual reliance, but rather knowledge by the cleric of the likelihood of reliance on pastoral counselling for depression, or knowledge the cleric should have had of the likelihood of reliance, where such reliance if it occurred would be reasonable.<sup>19</sup>

The elements of knowledge and reasonableness of reliance to which Barwick CJ referred in *MLC* were said by his Honour to be ‘essential’ elements.<sup>20</sup> That is not to say that a duty of care will arise for the provision of advice or information, or the provision of a service, if those elements are present.

Rather, it may suggest that such a duty of care will not generally arise unless they are. Previous cases are not of direct assistance in determining whether any further elements would be needed or would suffice in combination with those elements to establish the postulated duty of care.

The vulnerability of the plaintiff to the defendant’s conduct, or which may be viewed as essentially the same thing, the creation or increase of a risk of injury to the plaintiff by the defendant, has been referred to by members of the Court as relevant to the existence of a duty of care.

The precise significance of this element has not been comprehensively and definitively indicated by the Court. The guidance from the Court that is available would appear to permit a conclusion that it significantly favours the imposition of a duty of care.<sup>21</sup>

Vulnerability has been particularly important in cases involving pure economic loss. There is no convincing reason why increased economic vulnerability as a consequence of the defendant’s conduct should be relevant in an economic loss case but the increased vulnerability, if any, of a client as a consequence of pastoral counselling for depression should not be relevant.

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<sup>19</sup>Section 7.3.

<sup>20</sup>*MLC* at 570.

<sup>21</sup>Chapter nine.

Moreover, vulnerability has been considered significant in a case involving the provision of information.<sup>22</sup> As cases involving the provision of advice or information are analogous to cases involving the provision of a service, this element would therefore appear to have relevance to pastoral counselling for depression.

It is also appropriate to have regard to policy in determining whether to impose a duty of care.<sup>23</sup> The precise significance of policy has not been definitively determined by the Court.

## 19.2 A way forward

There is scope for choice, and potential for a variety of views, concerning the appropriate approach and conclusions in relation to the circumstances, if any, in which clergy who provide pastoral counselling for depression owe a duty of care:

[W]ithin the range of approaches and general principles to be found in ... High Court decisions there is scope for real choice at the trial level, especially in cases whose facts do not squarely fit established categories.<sup>24</sup>

It is submitted that whether a duty of care will arise for pastoral counselling for depression, in relation to harm other than mental harm,<sup>25</sup> may appropriately be determined by reference to the following questions, to be answered with regard to all the circumstances of the case:

(1) Whether the cleric knew, or a reasonable cleric would have known, of a likelihood of a client relying on the pastoral counselling for depression, if such a likelihood existed. Chapter eight addressed this question.

(2) Whether such reliance, if it occurred, would be reasonable. This was also discussed in chapter eight.

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<sup>22</sup> *Tepko*, as noted in section 9.3.

<sup>23</sup> Chapter sixteen.

<sup>24</sup> Phegan, C. 'The Tort of Negligence into the New Millenium' (1999) 73 ALJ 885, 900.

<sup>25</sup> Mental harm is discussed separately in section 18.10 and Appendix A.

(3) Whether pastoral counselling for depression has the potential to increase the vulnerability of the client, if reasonable care is not exercised. Chapter ten dealt with this issue.

(4) Whether harm to the client could be foreseen by a reasonable cleric as a result of an act or omission when providing pastoral counselling for depression. This was discussed in chapter eleven.

A negative answer to any of these four questions would mean no duty of care. An affirmative answer to all of them would make it necessary to consider:

(5) Whether it would be unreasonable, having regard to the public interest, for the cleric to be subject to a duty of care, in the circumstances of the case and in other cases of like circumstances; and

(6) Whether imposing a duty of care in the circumstances of the case and in other cases of like circumstances, would subject clergy to an unreasonable burden. In determining whether a duty of care would impose an unreasonable burden on clergy it is relevant to consider not only the burden of taking the precautions which reasonable care may require, but also any other burden involved, for example the cost of obtaining insurance.

An affirmative answer to either of the fifth or sixth questions would mean no duty of care. There is arguably no compelling reason to answer either of the fifth or sixth questions affirmatively.<sup>26</sup>

### **19.3 Comments on the suggested approach**

There are a number of grounds supporting the approach which has been suggested for determining whether pastoral counselling for depression by clergy will attract a duty of care. These include:

(1) It is supported by authority of the Court, to the extent that is possible in the absence of a directly relevant case. There is an absence of authority of the Court which would compel the taking of a different approach.

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<sup>26</sup>Chapter sixteen.

(2) It avoids subjecting a cleric to a duty of care unless the cleric has an appreciation of, or could be expected to appreciate, the implications of a failure to take care. It also ensures that a duty of care would not be imposed in circumstances where reliance on the counselling would be unreasonable.

(3) It emphasises the need for caution lest a duty of care be imposed in circumstances which would not be in the public interest or which would impose an unreasonable burden on clergy.

(4) It excludes pastoral care, as defined herein, from the postulated duty of care. A duty of care would not be appropriate for this form of communication.<sup>27</sup> Thus, it is submitted, when clergy come into contact with a depressed person they may, if they choose, discuss the depression, ask questions about the person or their depression, provide empathy to the person, and / or refer the person to another practitioner without the possibility of being subject to the postulated duty of care.

(5) To say that the approach is not productive of complete certainty as to when a duty of care will arise for pastoral counselling for depression would not be a valid criticism. Whether a duty of care will exist for pastoral counselling for depression depends on the facts of the particular case. A degree of uncertainty is therefore inevitable, and further: 'inevitably there will be imprecision in any developing area of the common law.'<sup>28</sup> Uncertainty has been minimised through the identification of a number of specific questions which indicate when a duty of care will or will not arise.

(6) The questions comprising the suggested approach may be viewed as components in an overall process of determining whether imposition of a duty of care would be reasonable. The Court 'has emphasised ... that the existence of a duty of care ... will depend on what is reasonable'.<sup>29</sup> The 'assessment of reasonableness' has recently been described in the Court as 'inherently adapted to vindication of meritorious claims':

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<sup>27</sup> Other than, perhaps, requirements not to disclose confidential information imparted by the other person and not to engage in sexual misconduct. Those matters are separate to the postulated duty of care and exploration of them is beyond the scope of the thesis, as discussed in section 5.19.

<sup>28</sup> *Hill* per Gaudron J at 199.

<sup>29</sup> *Derrington*, 611.

[T]he assessment of reasonableness, which informs each element of the cause of action, is inherently adapted to vindication of meritorious claims in a tort whose hallmark is flexibility of application. Artificial constrictions on the assessment of reasonableness tend, over time, to have the opposite effect.<sup>30</sup>

Conversely, an approach involving the assessment of reasonableness also permits the denial of unmeritorious claims.

(7) It also provides a rational basis for considering whether informal pastoral counselling for depression will attract a duty of care, as discussed in Appendix B.

#### **19.4 Degree of care, the duty to refer and other possible forms of care**

Conclusions in relation to degree of care, the duty to refer and other possible forms of care were stated in chapters thirteen, fourteen and fifteen. It is unnecessary to reproduce them here.

#### **19.5 Causal link between breach of the duty to refer and a suicide attempt, and thus damage resulting from the attempt**

Reasons for focussing on whether breach of the duty to refer could cause a suicide attempt and thus damage resulting from the attempt have been given.<sup>31</sup> Conclusions were given in chapter seventeen. Other modes of damage are noted in Appendix A.

#### **19.6 Liability of churches**

A client bringing a claim against a cleric may also make a claim against the cleric's church. Against that background, it was a secondary aim of the thesis to identify the law and main issues in relation to whether a church could be liable for a cleric's counselling negligence. Conclusions on this matter were given in chapter eighteen.

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<sup>30</sup> *Tame* per Gummow & Kirby JJ at 379.

<sup>31</sup> See the Preface, pages vi and vii, and section 1.3, page v.

## 19.7 Concluding remarks

It was seen at the beginning of the thesis that the majority of the Californian Supreme Court, in holding that no duty of care existed in *Nally*, stated:

Defendant Church had no professional or clinical counseling ministry, and its pastoral counseling was essentially religious in nature. Such counseling was often received through instruction, study, prayer and guidance ... According to the trial testimony of defendant Senior Pastor MacArthur, “Grace Community Church does not have a professional or clinical counseling ministry. We don’t run a counseling centre as such. We aren’t paid for that, and we don’t solicit that. We just respond as pastors, so what we do is on a spiritual level, and a biblical level, or a prayer level ...”. In essence, the defendants held themselves out as *pastoral* counselors - not as professional, medical or psychiatric counselors.<sup>32</sup> (emphasis in original)

The emphasis on the pastoral nature of the counselling would appear to leave limited scope for consideration of *all* the facts of the case. In that sense, such emphasis is arguably unsatisfactory.

Should a similar case arise in New South Wales the emphasis should be, it is submitted, on the facts of the case and the general principles of the law of negligence to which reference has been made herein.

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<sup>32</sup>253 Cal. Rptr 97 per Lucas CJ at 100; Mosk, Panelli, Arguelles and Eagleson JJ concurring (Cal. 1988).

## Appendix A

### OTHER MODES OF DAMAGE

#### Introduction

In chapter seventeen the issue of whether breach of the duty to refer could be the cause of a suicide attempt by a client, and therefore of damage resulting from the attempt, was examined. Consideration of other modes of damage is beyond the scope of the thesis. This Appendix, however, briefly discusses damage which might occur in the absence of a suicide attempt, whether from breach of the duty to refer or some other breach of duty.

The *CLA* imposes a new test, discussed below, for reasonable foreseeability in relation to mental harm.<sup>1</sup> If it is not satisfied there will be no duty of care.<sup>2</sup> Satisfaction of that test is presumably insufficient to establish a duty of care. In addition to satisfying that test, therefore, a plaintiff would need to demonstrate the existence of a duty of care through recourse to the common law of negligence.

It is submitted that the existence of otherwise of a duty of care in the context of pastoral counselling for depression and mental harm should be determined in the same manner that it has been suggested that this issue should be resolved in relation to pastoral counselling for depression generally, save in regard to reasonable foreseeability.

It was seen in previous chapters that where clergy provide pastoral counselling for depression they should comply with the duty to refer where it arises and warn the client not to cease using the main treatments for depression in reliance on the pastoral counselling for depression if such treatments are being used.<sup>3</sup> Clergy should also refrain from discouraging the client not to use the main treatments for depression, or providing counselling which may exacerbate the depression.<sup>4</sup>

If a duty of care was established and one or more of these requirements was found to have been breached, unnecessarily prolonged depression, and / or depression of greater severity might be alleged.

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<sup>1</sup> Section 32.

<sup>2</sup> *Id.*

<sup>3</sup> Chapters fourteen and fifteen.

<sup>4</sup> Chapter fifteen.

If the duty to refer was breached, the issue would be whether the breach unnecessarily prolonged or exacerbated the depression and whether that depression led to any further damage alleged, such as economic loss.<sup>5</sup>

This would involve the same issues as whether breach of the duty to refer was the cause of a suicide attempt, discussed in chapter eighteen, except that it would not always be necessary to consider whether the damage arose from a deliberate act of self-harm.

Resignation from a job due to depression where the employer was satisfied with the plaintiff's performance is a context where the question of the availability of damages for loss resulting from a deliberate act by the plaintiff would arise even in the absence of a suicide attempt.

If a breach of duty other than breach of the duty to refer was alleged, the issues in relation to causation would not be greatly different. Once again it would be necessary to consider whether the breach unnecessarily prolonged or exacerbated the depression and whether that depression led to any further damage alleged in the particular case, applying the principles of causation set out in chapter eighteen. It is unnecessary and not possible within space limitations to repeat that process herein in relation to every breach of duty and every type of damage.

There has been limited consideration in Anglo-Australian law of whether damages could be recovered for mental harm resulting from a want of care by a mental health professional, or by anyone else who provides counselling. In a now outdated article on the circumstances in which mental harm is compensable in the absence of physical injury, Mullany and Handford raised the issue but the purpose of their article did not extend to discussion of it.<sup>6</sup> Similarly, the issue has not been prominent in commentary on mental harm since the passage of the *CLA*.<sup>7</sup>

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<sup>5</sup> For example from loss of a job due to the depression.

<sup>6</sup> Mullany, N.J. & Handford, P.R. 'Moving the Boundary Stone by Statute - The Law Commission on Psychiatric Illness' (1999) 22 *UNSW Law Journal* 350, 408.

<sup>7</sup> Eg. Handford, P. 'Psychiatric Injury: The New Era' (2003) 11 *Tort Law Review* 13; Seeto, D.N. 'Shock Rebounds: Tort Reform and Negligently Inflicted Psychiatric Injury' (2004) 26 *Sydney Law Review* 293.

## **A.1 Mental harm not consequent upon physical injury from a suicide attempt - unnecessarily prolonged or exacerbated depression**

The *CLA* states that there is no liability for ‘pure mental harm’ unless it consists of a recognised psychiatric illness.<sup>8</sup> ‘Pure mental harm’ is defined as mental harm other than mental harm which is consequential on personal injury of any other kind.<sup>9</sup> ‘Mental harm’ means impairment of a person’s mental condition.<sup>10</sup> There is no requirement in the *CLA* that the mental harm consist of nervous shock.<sup>11</sup>

The *CLA* provides that there is no duty of care not to cause mental harm unless it ought to have been foreseen ‘that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken’.<sup>12</sup>

### **A.1.2 ‘Recognised psychiatric illness’**

The *CLA* does not define ‘recognised psychiatric illness’ nor indicate the basis on which the term is to be defined. Prior to the *CLA* the common law of negligence had drawn a distinction between psychiatric illness and mere emotional distress, and allowed recovery for the former in some circumstances, but not the latter.<sup>13</sup> ‘Little explicit attention has been given to the basis upon which the distinction between psychiatric injury and mental distress is to be made’.<sup>14</sup> According to Hayne J:

[P]sychiatry distinguishes between mere mental distress and psychiatric illness ... Recognising that psychiatry sees that distinction as being one of degree, not kind, and accepts that the distinction may change as medical knowledge expands, presents difficulty ... If mental distress and psychiatric illness are at opposite ends of a . spectrum ... how big is the middle band of that spectrum? How is [it] to be divided? Is it to be divided by psychiatric opinion? ... Or is the law to prescribe the criteria by which the distinction is to be made? ... so far the courts appear to have

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<sup>8</sup> Section 31.

<sup>9</sup> Section 27.

<sup>10</sup> *Id.*

<sup>11</sup> This is consistent with the common law: see eg. *Tame* per Gleeson CJ at 333: ‘I agree with Gummow and Kirby JJ that the common law of Australia should not, and does not, limit liability for damages for psychiatric injury to cases where the injury is caused by a sudden shock, or to cases where a plaintiff has directly perceived a distressing phenomenon or its immediate aftermath.

<sup>12</sup> Section 32(1).

<sup>13</sup> *Tame* per Hayne J at 414.

<sup>14</sup> *Ibid* 415.

been content to defer to the way in which psychiatrists distinguish ... the two.<sup>15</sup>

Depression is arguably a 'recognised psychiatric illness' within the meaning of the *CLA*.<sup>16</sup> Given the absence of an authoritative interpretation of the term 'recognised psychiatric illness' for the purposes of the *CLA*, a definitive conclusion on this issues is not possible.

### **A.1.2 'Normal fortitude'**

If depression was held to be a recognised psychiatric illness, it would be necessary to consider whether a client would be a person of 'normal fortitude' whom clergy ought to foresee as suffering unnecessarily prolonged or exacerbated depression if reasonable care were not taken.

The concept of 'normal fortitude' is not without difficulty. Gummow and Kirby JJ noted that 'the notion of a "normal" emotional susceptibility, in a population of diverse susceptibilities, is imprecise and artificial'.<sup>17</sup>

Application of the concept of normal fortitude where the cleric is aware that the client is depressed and the very reason for the relationship is that the client is depressed seems inapposite:

Cases where there is a relationship between the parties, like that of employee and employer, may, therefore, be thought to present separate questions about the application of a test of reasonable or ordinary fortitude. Even in such cases, I tend to the view that the test of reasonable or ordinary fortitude should still be applied at least in the absence of the employer having particular knowledge of the plaintiff's vulnerability.<sup>18</sup>

Nonetheless, the provisions of the *CLA* in relation to mental harm apply to pastoral counselling for depression, as they apply to any negligence claim to which the *CLA* applies,<sup>19</sup> and this includes a claim in relation to pastoral counselling for depression.<sup>20</sup>

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<sup>15</sup> *Id.*

<sup>16</sup> For example it is recognised in the American Psychiatric Association's *DSM-IV-TR*, as seen in chapter three.

<sup>17</sup> *Tame* at 384.

<sup>18</sup> *Tame* per Hayne J at 413.

<sup>19</sup> Section 28.

The *CLA* provides a non-exhaustive list of ‘circumstances of the case’ to be considered in determining whether the defendant ought to have foreseen that a person of normal fortitude might suffer a recognisable illness if reasonable care were not taken.

These include whether the mental harm was a consequence of nervous shock; whether the plaintiff witnessed, at the scene, a person being killed, injured or being put in peril; the nature of the relationship between the plaintiff and any person killed, injured or put in peril.<sup>21</sup> These circumstances are inapplicable to pastoral counselling for depression.

Another circumstance to be considered is whether a pre-existing relationship existed between the plaintiff and the defendant.<sup>22</sup> Pastoral counselling for depression involves such a relationship. This favours the existence of a duty of care in relation to mental harm, as the following comment by Hayne J suggests:

Where there is a relationship between plaintiff and defendant, such as that of employer and employee, and psychiatric injury is suffered in consequence of that relationship, it may readily be concluded that the relationship is such that the duties of care owed one to the other include a duty to take reasonable care to avoid inflicting psychiatric injury ...<sup>23</sup>

In Hayne J’s view, reference to ‘normal fortitude’, or what his Honour termed ‘ordinary fortitude’ ultimately requires reference to ‘what the lay member of the community may be expected to foresee’:

[R]equiring reference to the person of reasonable or ordinary fortitude may not be without difficulty ... ordinary fortitude is ... a control mechanism the application of which will require consideration of what, as a matter of general community expectation, could reasonably be foreseen to the reaction of the reasonable or ordinary person to a particular kind of stressful event. Although expert psychiatric evidence may be relevant to the inquiry about how a reasonable or ordinary person might react, it is important to recognise that the test requires reference ultimately to what the lay member of the community may be expected to foresee.<sup>24</sup>

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<sup>20</sup> Section 5.1.

<sup>21</sup> Section 32(2).

<sup>22</sup> *Id.*

<sup>23</sup> *Tame* per Hayne J at 413.

<sup>24</sup> *Ibid* 411.

It could be argued that a lay member of the community such a cleric,<sup>25</sup> could reasonably be expected to foresee that a want of care in relation to pastoral counselling could lead to unnecessarily prolonged or exacerbated depression.

It could also be argued that since depression is a recognised psychiatric illness, there is a pre-existing relationship between the cleric and the client, and the very purpose of that relationship is to solve the problem of the client's depression then damages for exacerbated or unnecessarily prolonged depression due to a want of care in providing pastoral counselling for depression should in theory be available, if a duty of care otherwise arose and there was a breach of duty. It may be difficult to distinguish between depression of different severities, thus it may be difficult to prove an exacerbation of depression.

If it were accepted that a client could recover damages for exacerbated or unnecessarily prolonged depression, there would appear to be scope for a plaintiff to recover damages for other recognised psychiatric illness that might occur as a result of that depression.

Consideration will therefore be given in the next section to whether there is a link between depression and psychosis, and between depression and schizophrenia, since they are among the most severe forms of psychiatric illness.

## **A.2 Mental harm not consequent upon physical injury from a suicide attempt - other psychiatric illness**

The questions of whether psychosis and schizophrenia are recognised psychiatric illnesses and could be suffered by a client of normal fortitude must await authoritative interpretation of the *CLA* for their definitive resolution. It is arguable that they are.<sup>26</sup>

### **A.2.1 Psychosis**

Psychosis is 'an impairment of mental functioning in which the individual loses touch with reality and usually experiences delusions and/or hallucinations'.<sup>27</sup>

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<sup>25</sup> A cleric is a lay community member in the sense of not being a mental health professional.

<sup>26</sup> Psychosis and schizophrenia have been recognised in *DMS-IV-TR* at 219-220 and 162 respectively.

<sup>27</sup> Parker, 2002, 131. See also *DSM-IV-TR Guidebook*, 219-220.

Psychosis may occur in conjunction with depression,<sup>28</sup> and some experts speak of ‘psychotic depression’<sup>29</sup> or ‘psychotic melancholia’.<sup>30</sup> Whether depression could cause psychosis in a previously non-psychotic person is another matter, however.

The *Australian Clinical Guidelines for Early Psychosis*,<sup>31</sup> which concern ‘first episode psychosis’ in the sense of ‘the first onset of [psychosis] in the lifetime of an individual’ do not explicitly identify depression as a cause of psychosis.

According to that document, ‘proximal risk factors’ for psychosis include ‘life events, substance abuse, [and] subjective / functional change in the person’.<sup>32</sup> ‘Distal (premorbid) risk factors’ include a family history of psychotic disorder, having a vulnerable personality, or having a history of head injury.<sup>33</sup>

Depression is merely one of numerous phenomena which may occur prior to psychosis:

The prodrome concept ... is essentially a retrospective concept. The vast majority of people who develop psychosis can be seen in retrospect to have experienced a period of pre-psychotic symptomatology and behaviour change. The prodrome may be considered to be the earliest form of psychotic disorder, or an at-risk mental state ... Prodromal features that have been associated with early psychosis [include] suspiciousness, depression, anxiety, tension, irritability, mood swings, anger, sleep disturbances, appetite changes, loss of energy or motivation, loss of energy or motivation, deterioration in work or study, emerging unusual beliefs ...<sup>34</sup>

There would thus appear to be little chance of a plaintiff proving that a breach of duty leading to unnecessarily prolonged or exacerbated depression was the cause of psychosis.

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<sup>28</sup> *NHMRC Guidelines*, xv.

<sup>29</sup> Eg. Parker, 2002, 133.

<sup>30</sup> Eg. Parker, 2002, 19. According to Parker at 131-132: ‘Psychotic depression [is] either a sub-class of melancholic depression or a separate sub-type altogether. Clinical features involve those most commonly over-represented in melancholic depression, including observable psychomotor disturbance, although these features are generally more severe, with the added presence of psychotic symptoms (that is, delusions and / or hallucinations).’

<sup>31</sup> National Early Psychosis Project Clinical Guidelines Working Party 1998 *Australian Clinical Practice Guidelines for Early Psychosis* Melbourne: National Early Psychosis Project, University of Melbourne.

<sup>32</sup> *Ibid* 12.

<sup>33</sup> *Id.*

<sup>34</sup> *Ibid* 13.

## **A.2.2 Schizophrenia**

According to Parker, schizophrenia is ‘a psychiatric condition where delusions and hallucinations are common; thinking, insight and attention commonly impaired; with behavioural problems frequent’.<sup>35</sup>

Depressive symptoms may be the prodrome of a schizophrenic episode.<sup>36</sup> However this does not mean that depression is a cause of schizophrenia. If anything, schizophrenia is more likely to lead to depression than vice versa:

[Schizophrenia is] a condition quite distinct from the mood disorders, although a significant percentage of those with schizophrenia develop a superimposed depression.<sup>37</sup>

A client would therefore have considerable difficulty in establishing that depression has led to schizophrenia, all the more so since ‘after nearly a century, the fact is that the cause or causes of schizophrenia remain unknown’.<sup>38</sup>

## **A.3 Economic loss resulting from pure mental harm**

The *CLA* does not appear to preclude recovery of damages for economic loss resulting from pure mental harm. Such damage would presumably only be recoverable if a duty of care applied in relation to the pure mental harm from which the economic loss was alleged to have resulted.

## **A.4 Physical injury in the absence of a suicide attempt**

It is probable that depression, by its nature, may lead to instances of deliberate self-inflicted physical injury which does not amount to a suicide attempt. The issues in relation to whether a causal link existed between breach of the duty to refer and the self-inflicted physical injury would be very similar to those regarding a suicide attempt.

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<sup>35</sup> Parker, 2002, 133. See also *DSM-IV-TR Guidebook*, 162.

<sup>36</sup> *NHMRC Guidelines*, 1.

<sup>37</sup> Parker, 2002, 133.

<sup>38</sup> McKenna, P.J. 1994 *Schizophrenia and Related Syndromes* Oxford University Press, 98.

If it was accepted that depression is a recognised psychiatric illness and the other requirements of liability were satisfied there would arguably be scope for recovery of damages for drug or alcohol abuse or eating disorders which could be proved to be a result of the depression.<sup>39</sup>

There would appear to be little further scope for a plaintiff to prove that a breach of duty was the cause of physical injury in the absence of a suicide attempt. Depression of itself does not have clear physical consequences:

A number of major depressed patients show suppression of some aspects of cell-mediated immunity ... [these] results were interpreted to indicate that major depression can compromise immune functions and is associated with reduced immune responsiveness ... However, the description of the effects of major depression and psychological stress on immune function in general terms of immunosuppression is an over-simplification, since the effects of depression and stress are very complex ... Depending on the nature of immune variables under consideration, some immune functions may be enhanced in depression while others are suppressed.<sup>40</sup>

## Conclusion

This Appendix discussed damage which might occur in the absence of a suicide attempt, whether from breach of the duty to refer or some other breach of duty. The *CLA* has impacted significantly on the recoverability of damages for mental harm and economic loss resulting from mental harm. In relation to the *CLA*, there is as yet ‘an element of guesswork as to the meaning and effect of some of the legislative changes’.<sup>41</sup> This applies in particular to the meaning of the terms ‘normal fortitude’ and ‘recognised psychiatric illness’ for the purposes of section 32 (1).

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<sup>39</sup>The *NHMRC Guidelines* state that depression is ‘linked to substance abuse and eating disorders’ (at 1).

<sup>40</sup>Maes, M. ‘The Immune Pathophysiology of Major Depression’ in Honig, A., Van Praag, H.M. (eds) 1997 *Depression: Neurobiological, Psychopathological and Therapeutic Advances* John Wiley & Sons, New York, 197-198.

<sup>41</sup>Dietrich, 18.

## Appendix B

### INFORMAL PASTORAL COUNSELLING FOR DEPRESSION

#### Introduction

This Appendix makes some brief observations concerning whether ‘informal pastoral counselling for depression’ may attract a duty of care.<sup>1</sup> It is beyond the scope of the thesis to consider this issue in its entirety.

Some discussion of it may be useful, however, as the roles of clergy are not always well-defined. Whetham states that clergy are often ‘asked to be generalists, given a blank job description and expected to answer every question’,<sup>2</sup> and that their roles are ‘very diffuse and multifaceted [and] varied and often ill-defined’.<sup>3</sup> In *Nally* much of the counselling provided by the defendants was informal.<sup>4</sup>

Pastoral counselling for depression and informal pastoral counselling for depression are two different situations. It is contended that the latter communication may or may not attract a duty of care depending on the circumstances of the particular case. It is further argued that the principles and policies of the law of negligence to which reference has been made in previous chapters provide an appropriate method for distinguishing between cases where a duty of care would and would not be appropriate.

The issue of whether words spoken on social or informal occasions may attract a duty of care has been the subject of limited attention in the Court, or elsewhere in Australian law. The following short comment by McHugh J, made in a judgment with which Gleeson CJ agreed, represents one of the few instances in which explicit reference has been made to the issue:

[T]he helpful bystander, who obligingly points the way to the traveller seeking guidance ... owe[s] a duty to take care that their directions ... do not lead to harm.<sup>5</sup>

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<sup>1</sup>This term was defined in section 4.6.

<sup>2</sup>Dr Paul Whetham, conversation with the author 31.07.02.

<sup>3</sup>Whetham, P.J. & Whetham, L. 2000 *Hard to be Holy: Unravelling the roles and relationships of church leaders* Openbook Publishers Adelaide, 17-18.

<sup>4</sup>See sections 1.3 and 2.1.

<sup>5</sup>*Crimmins* at 42.

This does not point the way towards a duty of care for informal pastoral counselling for depression by clergy, but rather provides limited guidance as to whether such communication will attract a duty of care.

In the absence of directly relevant authority from the Court, there is scope for choice in relation to the approach to be taken in determining whether informal pastoral counselling for depression will attract a duty of care. First, it is noted that pastoral care would not attract a duty of care.

### **B.1 No duty of care for pastoral care**

Pastoral care would not attract a duty of care. As defined herein, this form of communication does not involve an attempt to solve the problem of a person's depression in the sense of eliminating or substantially reducing the depression on an ongoing basis.<sup>6</sup> It therefore does not involve the undertaking of a task which could be reasonably relied on for that purpose, and does not have any relevant potential to increase the vulnerability of the other person.

Applying a duty of care to pastoral care would be inappropriate, as 'the ordinary courtesies and exchanges of life would become impossible if it were sought to attach legal obligation to every kindly and friendly act'.<sup>7</sup>

Where the communication goes beyond pastoral care and consists of informal pastoral counselling for depression, there is room for debate as to whether a duty of care may ever arise, as discussed in the next section.

### **B.2 A duty of care for informal pastoral counselling for depression?**

While concluding that the defendants owed a duty of care in the particular circumstances of *Nally*, the majority of the Californian Court of Appeal stated:

Nor do we hold a duty arises when a parishioner approaches a pastor after morning services for some casual advice about his emotional problems.<sup>8</sup>

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<sup>6</sup>Other than referral of the person to another practitioner.

<sup>7</sup>*Hedley Byrne* per Lord Morris at 494.

<sup>8</sup>240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987) per Johnson J at 226, Thompson ACJ concurring.

To expand on this example, a cleric and another person could have a lengthy impromptu conversation after a service, say of an hour or more, in which the other person confides they are depressed. The cleric could hypothetically provide the following advice: ‘You need to pray and read the Bible to recover from depression. God is the answer to all your problems. Nothing else will be of any use regarding depression’.

This situation is arguably significant, and would be more significant if the cleric repeated the advice to the same person on similar occasions over a period of weeks or months. On the other hand, if the cleric merely said, during a single conversation lasting only a few minutes, something along the lines of ‘Have you tried praying? That might help’, the case for a duty of care is considerably less convincing.

A rational basis is therefore needed to distinguish cases where a duty of care might be appropriate from those where it would be inappropriate. Such a basis is suggested in the next section.

### **B.3 Drawing the boundary between duty and no duty - assessment of reasonableness**

It is submitted that whether a particular instance of informal pastoral counselling for depression attracts a duty of care can be determined through application of the principles and policies to which reference has been made in previous chapters, as adapted to informal pastoral counselling for depression.

It should therefore be asked:

- (1) Whether the cleric knew, or a reasonable cleric would have known, of a likelihood of the recipient relying on the informal pastoral counselling for depression, if such a likelihood existed;
- (2) Whether such reliance, if it occurred, would be reasonable;
- (3) Whether informal pastoral counselling for depression has the potential to increase the vulnerability of the recipient, if reasonable care is not exercised;

(4) Whether harm to the recipient could be foreseen by a reasonable cleric as a result of an act or omission when providing informal pastoral counselling for depression.

A negative answer to any of these four questions would mean no duty of care. An affirmative answer to all of them would make it necessary to consider the following questions, an affirmative answer to either of which would mean no duty of care:

(5) Whether it would be unreasonable, having regard to the public interest, for the cleric to be subject to a duty of care, in the circumstances of the case and in other cases of like circumstances; and

(6) Whether imposing a duty of care in the circumstances of the case and in other cases of like circumstances, would subject clergy to an unreasonable burden.

These principles and policies may be viewed as components in an overall process of determining whether imposition of a duty of care would be reasonable. The Court ‘has emphasised ... that the existence of a duty of care ... will depend on what is reasonable’.<sup>9</sup> The ‘assessment of reasonableness’ has recently been described in the Court as ‘inherently adapted to vindication of meritorious claims’.<sup>10</sup>

The approach suggested in this section is therefore well-suited to resolving cases involving informal pastoral counselling for depression.

In relation to the first, third and fourth of the questions listed above, it is suggested that the relevant considerations would not be greatly different to those in the context of pastoral counselling for depression.<sup>11</sup>

In any event, it is beyond the scope of the thesis to further pursue those questions in relation to informal pastoral counselling for depression. The issue of whether reliance on a particular instance of informal pastoral counselling for depression would be reasonable in the circumstances may often be difficult, and is now considered.

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<sup>9</sup>Derrington, 611.

<sup>10</sup>*Tame* per Gummow & Kirby JJ at 379.

<sup>11</sup>These were discussed in chapters eight, ten and eleven. See particularly sections 8.2, 10.1 and 11.3.

#### **B.4 Reasonableness of reliance on informal pastoral counselling for depression**

In a general context Gibbs CJ stated that it would not be reasonable to rely on advice or information given casually on a social or informal occasion:

[P]eople speaking on social or informal occasions may not uncommonly make statements or express opinions with much less care than if they were giving advice or information professionally or for business purposes ... It would not be reasonable to act in reliance on advice or information given casually on some social or informal occasion ....<sup>12</sup>

Similarly Barwick CJ remarked:

[T]here must be ... occasions in connexion with the utterance of words which will not give rise to any duty ... Discussion and communication upon a social occasion ... or utterances on matters of no serious or business import are instances of such occasions.<sup>13</sup>

These comments were not made with informal pastoral counselling for depression in contemplation, and are not of direct or conclusive significance. It may be questioned whether informal pastoral counselling for depression should be characterised as a social occasion.

It may also be questioned whether the informality of an occasion should be the sole determinant of the reasonableness of any reliance on words spoken. The diminished capacity of a depressed person to exercise judgment in relation to the management of their depression, and a person's limited knowledge about treatments for depression may also warrant consideration.

That is not to say that any reliance on informal pastoral counselling for depression by a depressed person would be reasonable. The reasonableness of such reliance is ultimately a matter involving subjective individual judgment by the decision-maker in a particular case.

Whether imposition of a duty of care for informal pastoral counselling for depression would be unreasonable having regard to the public interest is considered in the next section.

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<sup>12</sup>*Shaddock* at 231.

<sup>13</sup>*MLC* at 569.

## B.5 Whether a duty of care is unreasonable having regard to the public interest

Hayne J remarked that ‘any decision about what is, or is not, socially useful is, by its very nature contestable’.<sup>14</sup> Similarly, whether a duty of care for informal pastoral counselling for depression is unreasonable having regard to the public interest is also debatable.

The social utility of informal pastoral counselling for depression and whether the imposition of a duty would deter its provision is relevant to the public interest. Brennan J referred to the undesirability of deterring socially useful communication through imposition of duty:

Helpful and friendly advice, even on matters of the gravest import, will often be proffered without any thought of the informant or adviser being responsible for its truth or soundness. To impose a legal duty of care on the unsolicited and voluntary giving of any information and advice on serious or business matters would chill communications which are a valuable source of wisdom and experience ...<sup>15</sup>

It is unclear whether all informal pastoral counselling for depression is a ‘valuable source of wisdom and experience’. Moreover, the public interest arguably extends to reducing the likelihood, if possible, of depressed people being diverted or delayed from use of the main treatments for depression through reliance on informal pastoral counselling for depression.

Counsel for the defendants in *Nally* appeared to have the public interest in mind when he argued, it is suggested hyperbolically:

[T]here are all kinds of informal counseling scenarios, such as those in this case. Friends offering advice, family trying to help a loved one, and the college dormitory situation with students trying to help roommates. If this new tort were to apply to all of those scenarios ... “you invite Pandora into California”.<sup>16</sup>

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<sup>14</sup> *Tame* per Hayne J at 417.

<sup>15</sup> *San Sebastian* per Brennan J at 372.

<sup>16</sup> Rex Lee, quoted in Weitz, 179.

References to ‘Pandora’ are unhelpful. To impose a duty of care for informal pastoral counselling for depression in one case does not mean a duty of care should be imposed for every instance of informal pastoral counselling for depression. Nor would it compel a conclusion that a duty of care should be imposed on the friends, family or fellow college students who try to help a depressed person.<sup>17</sup>

There is a difference between clergy and people such as friends, family or fellow college students of a depressed person. As noted already, clergy of some religions, in theory, possess divinely ordained authority. Many have authoritative titles such as Reverend Doctor, Senior Pastor, or Father.

In contract law courts have developed categories of relationship in which the influence of one party to a contract over the other in persuading the other to make the contract will be presumed to be undue and liable to be set aside by a court, unless the presumption is rebutted.<sup>18</sup>

Clergy are within such a category, whereas friends and fellow college students of a depressed person are not. Nor are family members.<sup>19</sup> This suggests the law is capable of distinguishing between clergy and other personnel where necessary.

Further, ‘clergy are in a position of trust and authority within the pastoral environment, which is characterised by inequality of power’,<sup>20</sup> and ‘the office [clergy] bear, the Master they serve ... and the influence and power they exert, throw upon them a burden of responsibility which is borne by no other class of men’.<sup>21</sup>

In *Nally* the Californian Court of Appeal, while concluding that the defendants owed a duty of care in the particular circumstances of that case, recognised that this did not have implications for the liability of other people:

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<sup>17</sup> In Australia, whether such personnel would have a duty of care would depend on the facts of the case in the unlikely event that one arises, not on whether or not clergy may be subject to a duty of care for informal pastoral counselling for depression in a particular case.

<sup>18</sup> Carter & Harland, 505.

<sup>19</sup> With the exception that parents of a minor are within such a category - see Carter & Harland, 512.

<sup>20</sup> Wood, 1001.

<sup>21</sup> Spring, 167.

We emphasize this duty does not extend to personal friends emotionally disturbed people may consult for advice and counsel about their problems.<sup>22</sup>

There is, therefore, arguably no reason to conclude that to impose a duty of care in a particular case involving informal pastoral counselling for depression would be unreasonable from the point of view of the public interest if a duty of care could otherwise be justified by reference to the other questions listed in section B.3, but again, that is a matter which is contestable. Whether a duty of care would impose an unreasonable burden on clergy is considered in the next section.

### **B.6 Whether a duty of care would impose an unreasonable burden on clergy**

The burden entailed by a duty of care depends in part on the degree of care required. A more relaxed degree of care than that applicable to pastoral counselling for depression is arguably appropriate. It is suggested the degree of care should consist only of the duty to refer, which was in any event the main constituent of the degree of care in relation to pastoral counselling for depression.

This is not a substantial burden. The burden of a duty of care is not limited to the burden of taking measures which reasonable care would require, however. Clergy may not always know with certainty when a duty of care may arise. This could weigh upon them as they go about their pastoral activities.

There are several matters which suggest this is neither a reason to grant clergy a total immunity from a duty of care for informal pastoral counselling for depression, nor a valid criticism of an approach based on the assessment of reasonableness.

First, it is important to note that a duty of care does not apply to pastoral care. It is only when a cleric attempts to solve the problem of a person's depression in the sense of eliminating or substantially reducing the depression through informal pastoral counselling for depression that any possibility of a duty of care applying would arise.

Second, where a cleric provides informal pastoral counselling for depression and observes that a person is reliant or likely to be reliant, the cleric would be alerted to the possibility of being subject to a duty of care.<sup>23</sup>

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<sup>22</sup> 240 Cal. Rptr. 215 (Cal. App. 2 Dist. 1987) per Johnson J at 226, Thompson ACJ concurring.

<sup>23</sup> Assuming an interest in the issue and access to legal advice.

Third, any uncertainty on the part of clergy as to exactly when they will be subject to a duty of care for informal pastoral counselling for depression should arguably be balanced with the risk that it may divert or delay a depressed person from use of the main treatments for depression in addressing the overall question of whether a duty of care would be reasonable. To rule out the possibility of a duty of care for informal pastoral counselling for depression, no matter how extensive, would mean that a cleric could recklessly divert or delay depressed people from use of the main treatments without the possibility of legal consequence.

Fourth, ‘inevitably there will be imprecision in any developing area of the common law.’<sup>24</sup> ‘The variety of possible circumstances will throw up ... subtle variations in generally similar cases ... so there must be some uncertainty associated with the flexibility that such complexity demands, and the process adopted by the High Court provides. It cannot be avoided’.<sup>25</sup>

That some uncertainty may exist is a situation to be recognised, not a problem to be solved. In a novel case it is necessary to examine all the facts to see whether a duty of care arises.<sup>26</sup> Gummow J stated: ‘There is no simple formula which can mask the necessity for examination of the particular facts ... this ... is not a problem to be solved; rather ... it is a situation to be recognised.’<sup>27</sup>

Fifth, taking an approach based on the assessment of reasonableness means there may be limited difference between cases where there is a duty of care and cases where there is not. This does not detract from the validity of drawing the boundary between duty and no duty in this manner. Hayne J stated:

[I]t is necessary to recall that the fact that there will be cases close to a boundary that is drawn between compensable and non-compensable events or conditions is an inevitable consequence of marking that boundary. To point to cases on either side of the line and remark on how close they are to the boundary, and thus to each other, is seldom a valid criticism of the boundary that is drawn.<sup>28</sup>

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<sup>24</sup> *Hill* per Gaudron J at 199.

<sup>25</sup> *Derrington*, 611.

<sup>26</sup> Section 6.3.

<sup>27</sup> *Perre* per Gummow J at 253.

<sup>28</sup> *Tame* per Hayne J at 415.

Sixth, there is no authority of the Court which would compel the taking of a different approach, and arguably no other approach could rationally be taken. The line of demarcation between duty of care and no duty of care for words is not the line between ‘counselling’ and ‘non-counselling’,<sup>29</sup> thus the adoption of a different definition of ‘counselling’ or ‘informal pastoral counselling for depression’ would not indicate when a duty of care should or should not arise where clergy seek to solve the problem of depression.

### **B.7 Both pastoral counselling for depression and informal pastoral counselling for depression are provided**

It is possible, as in *Nally*, that the overall relationship between the cleric and client could consist of both formal and informal counselling. If that was the case, it is suggested that the question would be whether there was a duty of care in the overall circumstances, not whether there was a duty of care in relation to one or the other forms of communication.

The same general principles and policies of the law of negligence referred to in this appendix and previous chapters would provide a satisfactory basis for resolving the duty of care issue. Whether a duty of care existed would depend on the facts of the case.

Before leaving this appendix, some brief comment is made about pastoral counselling for depression incident to counselling for other issues.

### **B.8 Pastoral counselling for depression incident to counselling for other issues**

When a cleric provides counselling within a session scheduled for the purpose of addressing a problem apart from depression, the conversation could turn to a client’s depression, if any. If the cleric then provided pastoral counselling for depression, the existence or otherwise of a duty of care would be assessed having regard to the principles and policies discussed herein. If the communication in relation to depression was merely one involving pastoral care, a duty of care would not apply.

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<sup>29</sup>This is obvious, and see generally for example the judgment of Barwick in *MLC*.

## Conclusion

This chapter made some brief observations concerning whether informal pastoral counselling for depression may give rise to a duty of care. It is beyond the scope of the thesis to consider the issue in its entirety.

Very little has been said by members of the Court in relation to whether words spoken on an informal occasion may attract a duty of care. The principles and policies referred to in this chapter arguably provide an appropriate basis for drawing the boundary between duty and no duty of care for informal pastoral counselling for depression.

These principles and policies may be seen as components in an overall process of determining whether a duty of care would be reasonable. The assessment of reasonableness in all the circumstances is 'inherently adapted to the vindication of meritorious claims',<sup>30</sup> and conversely to the denial of unmeritorious claims.

It is not a valid criticism of this approach to say that it is not productive of complete certainty. It is necessary to examine all the facts to see whether a duty of care arises.<sup>31</sup> A degree of uncertainty is therefore inevitable. That is a situation to be recognised, not a problem to be solved. It is clear, however, that a duty of care would not arise for pastoral care as defined herein.

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<sup>30</sup> *Tame* per Gummow & Kirby JJ at 379.

<sup>31</sup> Section 6.3.

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### Abbreviations

<i>AJP</i>	<i>American Journal of Psychotherapy</i>
<i>JPC</i>	<i>Journal of Psychology and Christianity</i>
<i>JPT</i>	<i>Journal of Psychology and Theology</i>
<i>JRH</i>	<i>Journal of Religion and Health</i>
<i>PP</i>	<i>Pastoral Psychology</i>

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**Further Research Undertaken** (Material read for the thesis but not referred to therein.)

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