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ARTICLE

Using Antipsychotics for Self-Defense Purposes by Care Staff in Residential Aged Care Facilities: An Ethical Analysis

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Abstract

People with dementia at times exhibit threatening and physically aggressive behavior toward care staff in residential aged care facilities (RACFs). Current clinical guidelines recommend judicious use of antipsychotic (AP) medications when there is an immediate risk of harm to care staff in RACFs and nonpharmacological interventions have failed to avert the threats. This article examines an account of how this recommendation can be ethically defensible: caregivers in RACFs may have a *prima facie* ethical justification, in certain cases, to use APs as an act of self-defense. The author examines whether such uses of APs meet the three commonly invoked conditions of ethically permissible acts of self-defense—namely, the conditions of liability, proportionality, and necessity—and argues that such conditions obtain only in a restricted range of cases. The liability constraint can be satisfied if residents are the only ones who are causally responsible for the threats they pose. Further, the condition of proportionality obtains if there is sufficient objective ground to demonstrate that the harm of using the medications does not outweigh the good to be secured. Lastly, the necessity condition obtains when the medications are used at their lowest effective dosage and caregivers in RACFs can reasonably assume that, for the purpose of averting threats posed by residents, the use of APs is the only available course of action. Not meeting any of these fairly stringent conditions renders uses of APs as acts of self-defense in RACFs morally impermissible actions.

Keywords: dementia; antipsychotics; ethical justification; self-defense; residential aged care facilities

Introduction

People with dementia in residential aged care facilities (RACFs) at times exhibit threatening and physically aggressive behavior toward co-residents and care staff.[1,2,3] To protect fellow residents and care staff in RACFs in such situations, current proposed clinical best practice guidelines recommend judicious use of antipsychotic (AP) medications when there is an immediate risk of harm and nonpharmacological interventions have failed to avert the threats.[4,5,6,7]

In the existing academic literature, the ethical permissibility of using pharmacological interventions, including the use of APs in RACFs to protect other residents from a physically aggressive resident, has received some attention.[8] Thus far, however, the use of APs to protect care staff in RACFs from physically aggressive residents has not been subjected to any sustained ethical scrutiny. Note that the main reason for such uses of APs is to benefit care staff in RACFs and not (other) residents. As such, the primary ethical justification for the practice cannot be beneficence considerations.

In this article, I examine an account of how the recommendation to judiciously rely on AP treatment to protect care staff in RACFs can be ethically defensible: Caregivers in RACFs may have a *prima facie* ethical justification, in certain cases, to use APs as an act of self-defense. Before outlining the structure of

the article, two clarifications about the scope of the article are in order. In what follows, I do not discuss whether care staff in RACFs have an all-thing-considered (or *ultima facie*) justification for the use of APs. Also, I do not rule out the possibility that care staff in RACFs may have other *prima facie* justifications for the practice, for example, in circumstances in which residents in RACFs pose an immediate risk of significant harm to both themselves and care staff or to both their fellow residents and care staff.

The article is structured as follows. Section "Three Conditions of Ethically Permissible Acts of Self-Defense" gives a brief overview of the existing philosophical literature on the ethics of self-defense and presents three conditions of ethically permissible acts of self-defense. Then, in Section "The Use of APs and Three Conditions of Morally Permissible Acts of Self-Defense," I examine in detail whether one can make a case for the use of APs by care staff in RACFs as a legitimate act of self-defense. I argue that, in a restricted range of cases, care staff in RACFs may have a *prima facie* justification to use APs on self-defense grounds. I conclude briefly afterward.

Three Conditions of Ethically Permissible Acts of Self-Defense

The philosophical literature on what counts as a morally permissible use of defensive force is vast and diverse. A detailed review of this literature goes beyond the scope of this article. Instead, for the purpose of my investigation here, I discuss three widely agreed-upon conditions for the morally permissible uses of force in acts of self-defense.

But first two issues need clarifications.

As Alexander notes, all self-defense acts "are preemptive uses of force."[9] That is, all acts of self-defense take place before perceived threats can be carried out. Because of this, when someone takes a defensive action to protect herself against a threat, there is always some uncertainty over whether the threat would have been carried out if she refrained from using the defensive force.

Although such epistemic limitations cannot be completely overcome, in this article, I take a practical and action-guiding approach to justifying the use of defensive force as proposed by Frowe.[10] According to this approach, defenders need to have some *reasonable* ground for their belief that they will be harmed unless they take defensive action. This approach particularly contrasts with approaches that require complete objective certainty about threats to be averted by taking self-defense actions. Approaches like this are too demanding and lack sufficient action-guiding appeal.

Second, caregivers in RACFs may not rely only or immediately on the use of APs as a self-defense measure. The administration of APs to those residents may follow or combine with other measures such as de-escalation through communication, physical restraint, or seclusion. Attempting to implement a pharmacological intervention might be in tension with efforts to de-escalate because some residents resist the administration of drugs.[11]

Despite not being an immediate or only potential response to threats by residents in RACFs, the defensive use of APs has, nonetheless, the most characteristic feature of self-defense acts: that caregivers anticipate that they will be harmed unless they administer the medications to physically threatening residents.

Having clarified the above points, I now go on to discuss the three conditions of morally permissible acts of self-defense.

The first condition is what McMahan calls "moral liability" to bear defensive harm.[12] This condition is met when the person to be harmed has acted in a particular way that results in an unjustified threat to a victim and harming the threatening person "would neither wrong him nor violate his rights."[13] Consider a villain who intends to murder an innocent person by pointing a loaded gun at him. Here, the villain intentionally poses an unjustified threat to the proposed victim and, as such, is clearly liable to be harmed (or even be killed) by him.[14] Following McMahan, stating that the villain is liable to be harmed implies that the victim, by taking the defensive action, will not morally wrong the villain, which also entails that the victim will not violate any of the villain's otherwise binding rights not to be harmed.

The second condition is that the degree of force used in acts of self-defense must be *proportionate* to the severity of the averted threat.[15,16,17] Using lethal force as a self-defense act against a non-violent form of aggression is a clear example of disproportionate, and thus impermissible, infliction of defensive harm.[18] An example of a proportionate self-defense act could be the use of lethal force when someone

faces a lethal threat. Here, the secured good (i.e., saving our lives from the threat) is equally comparable to the inflicted harm (i.e., the death of the threatening agent).

But proportionality determination is not always this straightforward. There are cases in which determining proportionality is complex. For instance, it is not clear, at least *prima facie*, that using lethal force ever meets the proportionality requirement when we face non-lethal threats such as kidnapping and torture or non-physical harms such as theft.

For the purpose of my investigation in this section, nonetheless, I refer to a basic definition of the proportionality requirement offered by Frowe. According to Frowe, the criterion of proportionality "stipulates that the harm I inflict upon my attacker must not significantly outweigh the good that I hope to secure thereby."[19] According to this definition, then, a self-defense act cannot be considered as a proportionate one, if the good to be secured is clearly of less moral weight than inflicted harm. For instance, an individual cannot break another's leg or an ankle to stop them from unjustifiably pinching her and claim this as a proportionate self-defense act.

Lastly, the third condition of morally permissible acts of self-defense is the *necessity* requirement. The basic, pretheoretical idea here is that the use of defensive force that inflicts harm H on an unjustified aggressor is morally permissible only if the defender does not have any alternative option(s) whether in kind or degree. Strictly speaking, this would imply that, for instance, when facing a physically aggressive resident, care staff in RACFs should leave the buildings instead of taking any potentially harmful defensive action.

But such demand is absurd. One way to avoid this problem, as Seth Lazar has noted, is to consider the condition of necessity as an evidence-relative requirement, and to assess alternative options available to a defender from the viewpoint of a reasonable person in the defender's situation.[20] This means that the infliction of harm H by a defender to avert an unjustified threat meets the condition of necessity only if "a reasonable agent with access to the evidence available to the defender would judge that there is no less harmful alternative" option.[21] For instance, it will not be morally permissible for a defender to use lethal force to avert the threat of unjustifiably being killed if a reasonable agent in the defender's position and with (sufficient) access to the evidence available to the defender judges that the defender in question has less harmful but effective options such as inflicting minor physical injury on the aggressor.

The Use of APs and Three Conditions of Morally Permissible Acts of *Self-Defense*

Now, the issue is to determine whether using APs to prevent harm to care staff in RACFs meets the above three conditions.

To argue that the use of APs meets the first condition, we need to show that residents in RACFs are morally liable to be harmed. This, however, is not an easy task.

Many physically threatening residents with dementia in RACFs pose the threat to care staff without clear intent.[22] Some behaviors exhibited by residents with dementia in RACFs, including physical aggression, might be their otherwise understandable response to unmet needs or aspects of the surrounding physical environment such as the degree of external stimulation.[23] The residents' threatening behavior might also be due to underlying psychological symptoms such as delusion or hallucination.[24]

In such cases, these residents resemble those who have been discussed in the literature on the ethics of self-defense acts as *innocent aggressors*. Broadly speaking, an innocent aggressor is one who poses a threat, for which she has no justification, to a victim "through an unintentional aggressive act."[25] Here, innocence refers to the fact that she has no control over her actions, and thus, does not pose the threat to the victim with clear intent. Besides people with dementia, other examples of innocent aggressors are infants or those whose consciousness is altered due to somnambulism or hypnotism.[26]

In the existing philosophical literature, there exist some disagreements over whether innocent aggressors are morally liable to the defensive use of force. One of the most notable critiques of holding innocent aggressors liable for defensive harm has been offered by Alexander.[27] His critique rests on the idea that to be morally liable for defensive harm, one has to be a *culpable* aggressor. Alexander defines

culpable aggressors as individuals who intentionally take a course of action that they believe will impose some risk of harm to a victim (or victims). Based on this definition, Alexander holds that an individual who poses a threat of harm to a victim but does not intend (or believe) to engage in a harm-inflicting activity is not a culpable aggressor and, consequently, cannot be held morally liable to the use of defensive force.[28]

If we accept Alexander's view, then, we cannot hold residents who unintentionally pose a threat of harm to caregivers liable to the defensive use of AP medications. This means that, by adopting Alexander's position, we face a serious problem to show that the use of APs as a self-defense act in RACFs meets the liability requirement when a resident's threatening behavior is unintentional.

Not all philosophers, however, assent to Alexander's view. McMahan,[29] *pace* Alexander, thinks that some innocent aggressors can be liable to the use of defensive force. According to McMahan, liability to defensive harm does not necessarily require culpability on the part of aggressors. That is, in McMahan's view, there might be cases in which an individual is liable to bear defensive harm, despite the fact that she is not culpable (i.e., she does not intend to engage in a harm-inflicting activity).

The following is the example that McMahan gives to clarify his point. A cautious and alert driver is driving a car. Suddenly, the driver loses control due to a major mechanical failure and is about to bear down on a pedestrian. The pedestrian will be killed unless she (the pedestrian) destroys the car by using an explosive device that she carries with her. McMahan considers the driver to be "an inadvertent threat" because the threat she poses to the pedestrian is not the consequence of prior (malicious) planning.[30] The driver is, therefore, not culpable since she does not intend to harm the pedestrian. In McMahan's view, the driver, nevertheless, is liable to the use of lethal force by the pedestrian. This is because, McMahan argues, the driver is a morally responsible agent who has chosen to drive a car while knowing that there is always a small chance that the car will become uncontrollable and potentially harm others.

For McMahan, what determines liability for defensive harm is moral responsibility and not culpability per se. On his account, some innocent aggressors are morally responsible for the threat they pose to others and, thus, are liable to bear defensive harm.

Can this be a possible way to show that residents who unintentionally pose a threat of harm to caregivers in RACFs are liable to be harmed? Below, I argue that the answer seems to be negative.

McMahan's approach requires determining that residents in RACFs are morally responsible for the threat they pose to caregivers. One necessary condition of moral responsibility, according to McMahan, is that innocent aggressors *foresee* threats they pose to other(s). That is, to be a morally responsible agent, on McMahan's account, an innocent aggressor should be aware that she poses some threat of harm to other(s).

This, however, is not the case with the aforesaid residents in RACFs. They cannot foresee the threats they pose to caregivers since they are hardly aware of the nature and extent of the threats. Those residents do not meet the condition of foreseeability as proposed by McMahan and, therefore, cannot be considered morally responsible for the threats they pose. This, in turn, implies that, on McMahan's account, the residents are not liable to bear defensive harm.

There is, nonetheless, one account of holding innocent aggressors liable for defensive harm that might have relevance to the abovementioned residents with dementia in RACFs.

According to Wallerstein,[31] we can, in principle, justify the use of defensive force to avert threats posed by innocent aggressors, but the considerations that underlie such justifications are different from those used to justify the infliction of defensive harm on culpable aggressors. Moral justifications for using defensive force to avert threats by culpable aggressors, Wallerstein holds, may turn on one of the following considerations. First, we might think that we have to assign more moral weight to the interests of defenders than to the interests of culpable aggressors, given that the aggressors are the ones who are at fault for the situation. Second, we might find justification in the fact that defenders are forced by culpable aggressors to choose between their own interests and others' interests.

Wallerstein notes that neither of the above considerations can help us justify the use of defensive force to counter threats by innocent aggressors. The first type of consideration fails to provide a justification for posing defensive harm to innocent aggressors because they do not appear to be morally at fault for the

threats they pose. Similarly, the second kind of consideration cannot yield a moral justification for harming innocent aggressors since, by definition, they do not exert any force on defenders to choose between the two different courses of action.

Instead, Wallerstein appeals to *a theory of forced consequences* to explain why it might be morally acceptable to use defensive force against innocent aggressors. This theory stipulates that, although innocent aggressors are not morally responsible for the threats they pose, they are *causally* responsible for the threats. That is to say, innocent aggressors, notwithstanding their lack of intentions, act in ways that result in situations in which defenders can either do nothing (and potentially suffer harm) or pre-empt and use some defensive force.

Wallerstein's account, unlike McMahan's, seems to apply to residents who unintentionally pose threats of harm to caregivers in RACFs. It does not require showing that the residents are morally responsible for threats they pose to care staff. Wallerstein's account simply demands that residents should be causally responsible for the threats. This requirement can be met in cases in which the residents' threatening behaviors are unprovoked, that is, when the residents are the only ones who are causally responsible for the threats.

But the requirement cannot be satisfied if caregivers themselves are parts of the causal chains that lead to residents' threatening behaviors. This occurs when, for instance, residents' physical aggressiveness is in response to caregivers who adopt verbally abusive attitudes toward them. Previous empirical research has shown that, at times, caregivers in RACFs adopt "an authoritarian attitude towards the residents, involving themselves in agitated discussions, raising their voices, and berating the resident."[32] In these cases, Wallerstein's account does not yield any justification for posing defensive harm to the residents. This is because, in these cases, the causal responsibility for the threats can be attributed (although not necessarily equally) to both caregivers (*qua* defenders) and the residents (*qua* innocent aggressor).

I turn now to the proportionality constraints on the use of APs as a self-defense measure in RACFs.

The main question to be addressed is: Under what circumstances is the severity of threats posed by residents in RACFs to caregivers proportionate to the harm of using APs in ways that are not directly related to the clinical needs of the patients? Here are two examples to illustrate what might be considered as disproportionate and potentially proportionate uses of APs as self-defense acts.

Mr B is a 65-year-old former rugby player with frontotemporal dementia who now resides in a RACF. He has displayed unprovoked, violent behavior toward caregivers by throwing things at them. The caregivers attempted to ease the situation by talking to Mr B to calm him down and/or to distract him. This strategy was not successful, and Mr B's violent behavior intensified. Feeling threatened by Mr B's behavior, the caregivers, after consulting the physician on duty, decided to manage the situation by physically restraining the resident and giving him an intramuscular injection of a conventional AP (haloperidol). There was no clear indication that Mr B might exhibit similar threatening behavior in the future. Despite this, caregivers continued administering the medication to Mr B in the oral form (tablet), on a continuous and long-term basis, in anticipation of his future harm-inflicting behavior.

The above case raises two distinct questions regarding the proportionality criterion of legitimate self-defense acts.

The first is whether the harm of the initial administration of haloperidol is proportionate to the primary threat. The second question is whether the harm of continuous and long-term use of the medication to the resident is proportionate to the harm to be prevented to the caregivers after the incident. Below is a discussion of how these two questions need to be answered differently.

The answer to the first question may be positive. The initial administration of the AP medication to Mr B was a one-off treatment. If there was no clear contraindication for using haloperidol in the above case (e.g., the presence of dementia of Lewy-Body type), the risk of harm associated with the initial AP treatment to Mr B would not be very significant. On the contrary, the averted threat from Mr B's violent behavior was of considerable magnitude. The good secured by the initial injection of haloperidol, thus, does not appear to be less than the (potential) harm inflicted on Mr B.[33] This means that the initial use of the AP medication can be considered a proportionate defensive response to the threat posed by Mr B's violent behavior toward the caregivers.

But we cannot give an equally satisfactory positive answer to the second question. The risk of adverse effects of APs increases when the medications are used for longer periods of time.[34] Also, the long-term use of APs may undermine adequate pain management in people with dementia.[35] As such, the harm of long-term administration of haloperidol to Mr B is much greater than the harm of the one-off injection of the medication.

These observations have important implications for how we should judge proportionality with regard to the continued use of haloperidol in this case as a self-defense act. Given its greater associated risk of harm, the long-term administration of the AP medication to Mr B meets the criterion of proportionality only if we can demonstrate that, by doing so, we can also achieve much greater good than that secured by the initial use of the medication.

This is, however, a very difficult task. Remember that there was no indication that Mr B might exhibit similar violent behavior in the future.[36] The averted threat by continued use of the medication was a fairly remote and speculative possibility. Although, as mentioned before, there is always a level of epistemic uncertainty over whether a threat will be carried out in all uses of defensive forces; the lack of certainty about the threat to be averted by the continued use of the AP medication in the above example is very significant. There are, therefore, insufficient factual grounds to make the claim that continued administration of the AP medication to Mr B realizes considerable good, which, in our proportionality calculation, may be on a par with or greater than its associated risk of harm.

I now move on to consider to consider whether the defensive use of APs in RACFs can meet the condition of *necessity*. This condition requires that caregivers in RACFs, based on the evidence available to them, can reasonably assume that, for the purpose of averting the threat, there is not any equally effective but less harmful intervention than the use of APs.

Consider again the initial injection of haloperidol to Mr B. As per the above description of the case, it is not clear that the use of AP medication could meet the condition of necessity. We need additional details to judge whether the initial administration of haloperidol meets the requirements of necessity. It would fail the necessity requirement if, for instance, caregivers could manage the situation by using other less harmful pharmacological or non-pharmacological interventions. Similarly, the condition of necessity does not obtain if caregivers could avert the threat by injecting a lower dose of haloperidol. The use of haloperidol, however, can meet the requirements of necessity if caregivers can reasonably assume that, for the purpose of averting the threat, (1) there was not any equally effective but less harmful intervention and (2) lower doses of haloperidol would be ineffective.

Before concluding, it seems helpful to discuss all three conditions discussed before in relation to a different case.

Mr J is a 70-year-old former policeman with mild to moderate Alzheimer's type dementia who now resides in a RACF. For the past few weeks, he has been exhibiting aggression toward the care staff on a number of occasions. The care staff has managed the situation by talking to Mr J and attending to any unmet needs, which may be triggering/intensifying his aggressive symptoms.

It is now 6 p.m. and Mr J, while walking with a nurse (Mrs Q) in the hallway, is swearing loudly and shouting at others, demanding to know where he is right now. The caregiver tries to pacify Mr J by talking softly to him and letting him know that he is in a care setting.

Suddenly, Mr J attacks Mrs Q and attempts to bend her arm. Other caregivers notice the incident and try to help her. Mr J threatens others that if they get closer, he will kick Mrs Q in the stomach. Given the absence of any other alternative option to avert the risk of harm to Mrs Q, three of the care staff members restrain Mr J in the safest way possible and direct him to his bed. Subsequently, after consulting with the physician on duty, Mr J is given an intramuscular injection of haloperidol in the lowest possible dose to ensure sedation.

Mr J wakes up the next morning with a faint memory of what happened last night and seems slightly frightened. The care staff on the morning shift are informed about what happened last night and determine that Mr J's fear could be a consequence of the incident. They attempt to talk to Mr J in a calming way and give him the option to eat/drink and get bathed at his desired times. Mr J states that he would prefer to eat now but be bathed later in the day after the end of his favorite TV show.

There is a change of shift at noon. The new care staff, although informed, due to competing demands on their time, want to bathe him now even though the TV show is still going. Mr J resists the bathing. He attacks one of the caregivers again. The staff restrain Mr J again and give him another intramuscular injection of haloperidol.

The initial use of the AP medication (and the associated restraint) was an act of self-defense. The act meets all three conditions of permissible infliction of defensive harm as discussed previously. First, it seems that despite being an innocent aggressor, Mr J is liable to bear the defensive harm. This is because the caregivers do not play any causal role in the occurrence of the attack. Second, the harm of a one-off injection of the AP medication seems to be proportionate to the harm to be averted. Finally, the act in question can also meet the necessity condition: the caregivers can reasonably assume that the injection of the AP medication (and the associated restraint) is the only available course of action to avert the threat of harm posed by Mr J, and the medication is used at its lowest effective dosage.

In contrast, the second administration of the AP medication to Mr J cannot be considered an ethically permissible act of self-defense. This is because the liability condition does not obtain: We cannot reasonably hold Mr J liable to bear the defensive harm as the caregivers on the third shift play a direct causal role in the occurrence of the violent incident by breaking the agreement about the timing of Mr J's bath. As such, the caregivers do not have a *prima facie* justification for the second use of the AP medication.

Conclusion

Caregivers in RACFs have a *prima facie* justification for the use of APs as a self-defense measure only in a restricted range of cases. The liability constraint can be satisfied if residents are the only ones who are causally responsible for the threats they pose. Further, the use of APs as a self-defense measure by caregivers in RACFs meets the condition of proportionality when we have sufficient objective ground to demonstrate that the harms of using the medications do not outweigh the good to be secured. The necessity condition obtains when the medications are used at their lowest effective dosage and caregivers in RACFs can reasonably assume that, for the purpose of averting threats posed by residents, the use of APs is the only available course of action. Not meeting any of these fairly stringent conditions renders the use of APs as a self-defense measure in RACFs a morally impermissible action.

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Notes

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13. See note 12, McMahan 2005, at 386.
14. To be clear, McMahan draws a distinction between liability and desert. When someone deserves to be harmed, she is also liable for the inflicted harm. But liability does not necessarily entail desert. That is, one can be liable to be harmed without deserving to be harmed. For more See note 12, McMahan 2005, at 386.
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18. There might be cases in which the use of disproportionate force is the only way to avert a threat. For instance, one might find herself in a situation in which the only way to prevent a mugger from inflicting injury and stealing personal property is to shoot and likely kill the mugger. In situations like this, some hold that it is plausible to argue that this act of self-defence, despite not meeting the requirement of proportionality, is morally permissible. For more on this See note 15, Coons, Weber 2016.
19. See note 17, Frowe 2015, at 11.
20. See note 16, Lazar 2012, at 9.
21. See note 16, Lazar 2012.
22. Here, I do not discuss cases in which residents exhibit unprovoked aggressive and physically threatening behaviour toward care staff with clear intent to harm. This reflects the assumption that in such cases, the use of APs on self-defence grounds is much less contentious.
23. See Zeisel J, Silverstein NM, Hyde J, Levkoff S, Lawton MP, Holmes W. Environmental correlates to behavioral health outcomes in Alzheimer's special care units. *Gerontologist* 2003;**43**(5):697–711.
24. See Graneheim UH, Hörnsten Å, Isaksson U. Female caregivers' perceptions of reasons for violent behaviour among nursing home residents. *Journal of Psychiatric and Mental Health Nursing* 2012;**19**(2):154–61.
25. Wallerstein S. Justifying the right to self-defense: A theory of forced consequences. *Virginia Law Review* 2005;**91**:999–1035, at 1001.
26. See note 9, Alexander 2016, at 26.
27. See note 9, Alexander 2016.
28. Michael Otsuka has developed another similar critique by arguing that, in the context of self-defence actions, (agency-lacking) innocent aggressors should have the same moral protection that innocent bystanders have. See Otsuka M. Killing the innocent in self-defense. *Philosophy* & Public Affairs 1994;**23**(1):74–94.
29. See note 12, McMahan 2005.

30. See note 12, McMahan 2005, at 394.
31. See note 25, Wallerstein 2005.
32. See note 24, Graneheim et al. 2012, at 157.
33. Note that in this proportionality calculation, and for simplicity's sake, I only factor in harms of AP treatment and not the harms associated with physically restraining Mr B.
34. SeeIsaksson U, Graneheim UH, Åström S, Karlsson S. Physically violent behaviour in dementia care: Characteristics of residents and management of violent situations. *Aging & Mental Health* 2011;**15** (5):573–9.
35. Flo E, Gulla C, Husebo BS. Effective pain management in patients with dementia: Benefits beyond pain? *Drugs & Aging* 2014;**31**(12):863–71.
36. To the best of my knowledge, there is no existing empirical research specifically investigating the natural history of other-harming behaviors exhibited by people with dementia in RACFs. This means that there is no empirical ground for predicting whether an individual with dementia who exhibits other-harming behaviour at T1 is likely to exhibit the same behaviour at T2.

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