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GUIDELINE ON ASSISTING HOSTAGE NEGOTIATION FOR MENTAL HEALTH PROFESSIONALS

Medical Development Division,
Ministry of Health Malaysia

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MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH MALAYSIA

This policy was developed by the Medical Services Unit, Medical Services Development Section of the Medical Development Division, Ministry of Health Malaysia and the Drafting Committee for the Guideline On Assisting Hostage Negotiation For Mental Health Professionals

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DIRECTOR OF HEALTH

The safety of a country and her people are of utmost importance. Threats may be present in many forms and hostage-taking situation is one of them. Criminals, prisoners, terrorists and persons with mental health issues are often the categories for hostage takers. These, in many instances, may be regarded as a matter of life and death situation.

In recent years, we have witnessed a spate of hostage taking incidents in our country. The National Security Council (NSC/MKN) is the key player in hostage negotiations with professional assistance from other agencies. The Ministry of Health and mental health professionals are amongst them. The role of mental health professionals has been increasingly recognized in assisting negotiation process, worldwide.

Hence it is timely that a guideline on hostage negotiation for mental health professionals be put in place to aid them in helping the NSC during these challenging and stressful conditions.

I would like to take this opportunity to thank the Ministry of Health Psychiatric Service Team as well as those who were directly or indirectly involved in preparing and developing this document. I hope that it would be fully utilised as a guide when the need arises to help in hostage taking situations.

FOREWORD

NATIONAL ADVISOR OF PSYCHIATRIC SERVICES AND MENTAL HEALTH

Hostage negotiation is a law enforcement skills and technique used to communicate and negotiate whenever there are any life-threatening incidents involving hostages and barricaded situation. Hostage taking situation has occurred worldwide including Malaysia. The earliest high-profile hostage case in Malaysia was in August 1975 when The Japanese Red Army took over 53 hostages, mostly Malaysians, at the AIA building in Jalan Ampang, Kuala Lumpur. Another high-profile hostage case took place in July 2000, when 29 militants of the Al-Ma'unah group took over a military base in Sauk, Perak.

In retrospect, there was no formal involvement of mental health professionals to assist in the hostage negotiation situation. However, times have changed and there is an increasing need of psychiatrist or psychologist to be part of the negotiation team. To understand and ease the negotiation process, psychiatrists or psychologists are expected to provide mental health assessment of negotiators, hostage takers and hostages.

This guideline is developed to equip and to guide mental health professionals in giving their best in these situations by increasing their knowledge and developing their skills in this particular area.

Last but not least, I would like to extend my sincere appreciation to guidelines development group for their tireless and well-thought efforts put into its development and publication. I hope that it will serve its purpose in aiding the mental health professionals in managing these crisis situations in future.

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Dr. Toh Chin Lee

CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

Hostage and barricade situations occur frequently in law enforcement practice. Large-scale standoffs, such as the Branch Davidian incident often attract intense media coverage and capture the public's attention. Closer to home, the Al Maunah incident and the Lahad Datu, Sabah standoffs are two examples of incidents that had caused much furore in our country. More commonly, the police department deals with hostage/barricade subjects whose motivations are influenced by political, religious or psychological cause.

A hostage situation occurs when one or more persons are held against their will, and release dependent upon certain demands being met. Hostage situations are fluid. They differ from one another in every aspect including number of persons involved, goals of hostage taking, personalities of hostage takers (HT) and others which are often discovered during the negotiation process.

Two types of hostage taking situations i.e. barricade/siege and hideout. There are distinctions between the two. As the location is known in barricade situation, they are dependent on the government to sustain their logistical basic needs and medical attention. There is a quasi-symbiotic relationship between HT and hostages to ensure the demands are met. In this situation, the incidence may be shorter in duration and negotiation can be initiated by both parties.

In hideout situation, the HTs are anonymous, mobile and not restricted by the government as the location is unknown. Hence, the negotiation can be longer and the put the hostages at higher risk. The situation can evolve into a barricade situation when the hideout location is discovered.

These situations are both challenging and stressful moments for the response team. For police response to be successful, each unit and individual needs to understand clearly their functions as well as the roles of the others. In the pursuit of the basic policy of "no concession to HTs", the goal of any negotiation is the preservation of life and the safe release of hostages. Containment, the threat of force, time and communication were the necessary conditions for effective negotiations (Mcmains & Mullins, 1996; Stratton 1978a,b).

In incidents involving hostage taking, the teams who are involved in the provision of assessment and management of the crisis include Mental Health Professional (MHP) and Mental Health and Psychosocial Support Team (MHPST) respectively. MHPs are typically psychiatrists or clinical psychologists who are required to provide

psychological assessment as part of the negotiation team, and MHPST involves in providing Psychological First Aid(PFA) and debriefing.

MHPs contribute to an increase in incidences of surrender of hostage takers, a decrease in incidents resulting in tactical assault, and a reduction in events with injuries or death to the hostages.

Given the complexity and danger associated with hostage/barricade situations, MHP can provide valuable assistance to negotiators in several areas (Feldmann, 1998) namely;

- Assessment and profiling of hostage takers and hostages
- Evaluation of negotiation and management strategies
- Monitoring of stress during hostage/barricade situations
- Training of negotiators on basic mental health issues
- Development of training scenarios for both negotiators and MHP.
- Research into the characteristics of hostage/barricade incidents and success of various negotiation strategies

Adequate clinical training and experience is essential, as is familiarity with basic forensic issues. An understanding of the organization of law enforcement agencies, and a willingness to work within that system, is crucial. The MHPs should also be familiar with basic hostage negotiation concepts. They must never attempt to assume the role of negotiator; this is a function reserved only for trained negotiators.

1.2 OBJECTIVES OF THIS GUIDELINE

(i) To guide MHP in assisting and handling hostage negotiation.
(ii) To provide MHP with the necessary skills to assist in handling hostage negotiation.
(iii) To understand the role of the Negotiation Team and the interaction with all the related agencies
(iv) To provide the background information of the roles of key agencies/units

This is in consonant with the National Security Council Directive 18 (MKN Arahan No. 18) which cannot be shared in this guideline as it is confidential.

1.3 ACTIVATION PATHWAY OF MENTAL HEALTH PROFESSIONALS (MHP) AND MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT TEAM (MHPST) IN HOSTAGE SITUATIONS

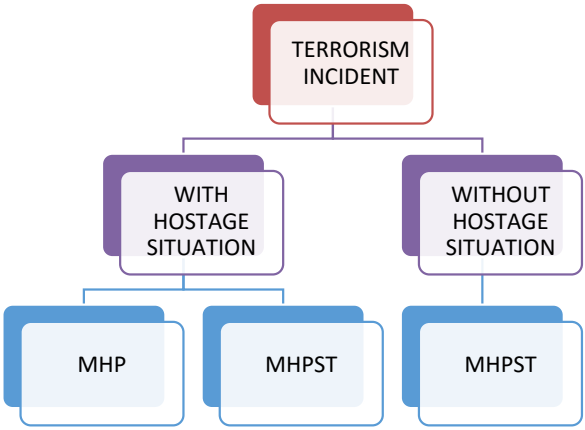


Figure 1: Pathway for involvement of MHP and MHPST

1.4 THE ACTIVATION PROCESS FOR MHP AND MHPST IN TERRORISM WITH HOSTAGE SITUATION

Whenever an act of terrorism is reported, the National Security Council Directive No. 18 shall be activated. The Director General (DG) of Health shall be alerted for deployment of MHP in the negotiation team. DG of Health shall also inform the respective State Director of Health, who shall then notify the respective Hospital Director. The appointed MHP shall immediately report to the head of negotiation team at the scene to perform the task until the situation is under control and resolved. Additionally, the MHPST will be activated. Involvements of MHP and MHPST are shown as in Figure 1 and Figure 2.

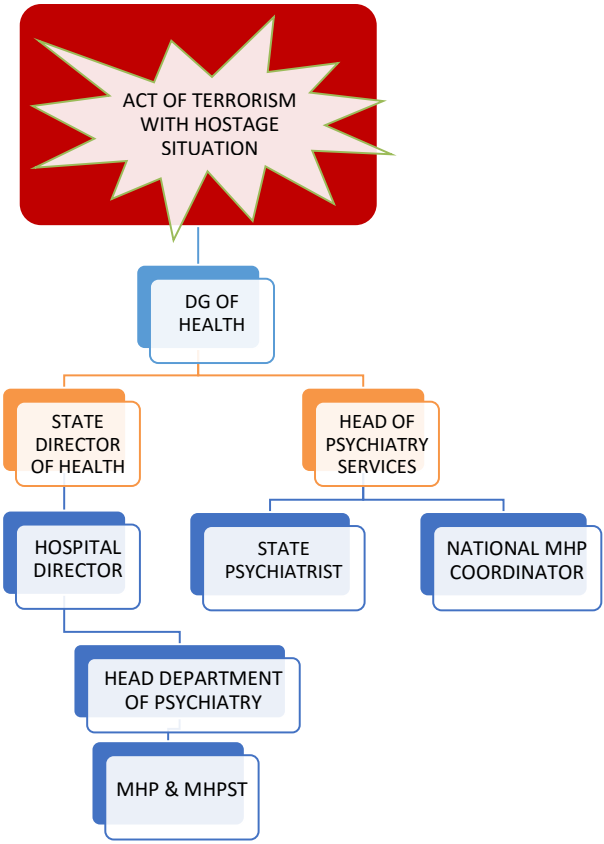


Figure 2: Activation mechanism flowchart for mental health professionals in terrorism involving hostage situations.
(NSC Directive No. 18)

CHAPTER 2

UNDERSTANDING THE BASIS OF NEGOTIATION PROCESS

2.1 DEFINITION OF NEGOTIATION

Negotiation is defined as a discussion aimed at reaching an agreement which involves an interpersonal and/or intergroup dialogue with conflicting interests to reach a beneficial outcome to all parties.

Hostage negotiation can occur in the following situations:

a) Domestic siege

There are few situations that can trigger domestic siege. For example; when an individual become intoxicated and under influence of illicit substance and under severe stress, a couple who have disputes may confines his/her partner in a place by force or a parent may take a child hostage in a custody battle.

b) Criminal siege

This can be planned or unplanned. The use of hostages can be part of the criminal act to ensure the escape, to gain ransom, or for some other purpose which may have been planned from the very beginning. A criminal siege is rarely deliberate. When the hostage taking is unplanned it can be violent. This happens when the criminals take a hostage accidentally, as a fight or flight response when the criminal act is discovered and interrupted, or they feel trapped without a preconceived plan. They use the hostages as an exchange for their escape.

c) Psychiatric disorder and mental health issues

Hostage takers with mental disorder may cause a hostage situation can be more dangerous as their behaviour is unpredictable with risk of violence. The most common psychiatric diagnosis associated with hostage takers are Schizophrenia Spectrum and Other Psychotic Disorder, Depressive Disorder and Personality Disorder (Antisocial Personality Disorder and Borderline Personality Disorder)

d) Political siege

The political hostage taker usually has specific and obvious ideological motive. Many of these HTs are willing to die for their cause and to kill others. Structured groups such as terrorists may take hostages, usually to achieve publicity or to force the release of political prisoners, or gain revenge. There is high possibility of the hostages being killed as the terrorists would have expressed their intentions of executing the hostages and willing to die as martyrs.

e) Prison siege

This happens when the prisoners take hold of hostages to emphasize their demands for change (better food, more visits) or to assist in an escape. This can be a dangerous situation for hostages (usually prison warden or other prison personnel, but also sometimes fellow inmates) because the prisoners may feel they have nothing to lose.

2.2 NEGOTIATION PROCESS

The negotiation process involves preparation, drawing up strategies and the negotiation proper that are carried out by different individuals. There are 4 stages in negotiation process. The stages are :

a) The Preliminary Stage

This stage involves establishing rapport,and facilitating agreement on agenda and ground rules. Issues and roles are identified and timelines are established.

b) The Opening Stage

This involves opening position or initial offer. The other party's opening position or initial demand must be clarified and must be tested in a logical and rational manner.

c. The Exploratory Stage

This involves identifying the other party's underlying demands and needs through active listening and probing through asking question. It tests alternative options of exchange. Concessions or compromises may be made in order to achieve agreement.

d. The Conclusion or the Closing Stage

At this stage, terms must be matched to the needs, and agreement must be formalized after resolving the potential problems and all lingering concerns. Ensure that what has been agreed upon is implemented as planned using the appropriate form such as a contract or a memorandum of agreement.

Demand and deadlines from HT are important elements in negotiation. Therefore there are some dos and don'ts during the negotiation, which should be carried out mainly by the primary negotiator (refer Appendix 1).

In some cases where medical assistance is needed inside the stronghold, the negotiators should evaluate the circumstance of the hostage-patient and work for the hostage-patient to be sent out of the stronghold especially if the hostage-patient is critically ill. If the hostage-takers decline to release the hostage-patient then a doctor should be called upon to talk to hostage-taker or hostages to administer the treatment upon his instruction. However, doctors should not be sent inside the stronghold for safety reasons. If there is a doctor among the hostages, his/her identity should be kept confidential from the HTs unless necessary. If they insist that the doctor be brought inside, then this should be considered for strategic purposes and treat it as a chance to collect facts inside the stronghold.

There are some generally reliable prognostic indicators of how things are progressing during negotiation (Greenstone, 1995; Lanceley, 1999; McMains & Mullins, 1996; Noesner, 1999). The positive sign of negotiation progress may include:

- Sustainable and more frequent communication with the HT
- Less violent and threatening speech of HT
- Deadlines may pass unnoticed and;
- Passage of time without injury to hostages.

Negative signs may include:

- Displays poor rapport and refusal of the HT to talk
- The HTs who insist on face-to-face negotiations and;
- The use of alcohol or drugs by HT

(This chapter is adapted from chapter 2 of Hostage Negotiation Handbook of Philippine. National Police (2011).

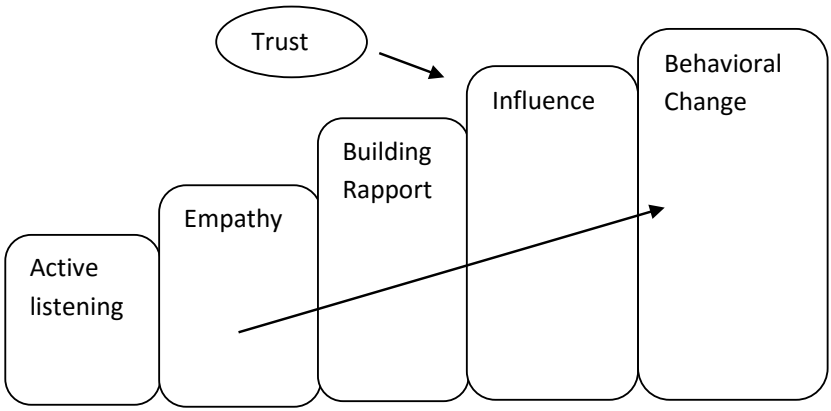
2.3 COMMUNICATION IN HOSTAGE NEGOTIATION

There are several general communication strategies that have been suggested to be applied when dealing with the hostage negotiation situation (Miller, 2005). These may include proper introduction, develop rapport and trust, clear conversation and avoid profanity. The aim of communication is to gather information about the hostage taker's background, criminal history, mental health history, family structure, employment status and other relevant history.

One of the example of effective communication strategy is The Behavioural Change Stairway Model (BCSM) which was developed by the FBI's Crisis Negotiation Unit (Gregory et al. 2005).

BCSM consists of five stages which are active listening, empathy, rapport, influence, and behavioural change.

Below is the Behavioral Change Stairway Model



CHAPTER 3

ROLE OF THE MENTAL HEALTH PROFESSIONALS (MHP) IN THE HOSTAGE NEGOTIATION TEAM

3.1 HOSTAGE NEGOTIATION TEAM

The negotiation team comprises of trained and experienced negotiators who are proposed and chosen upon assessment as per NSC Directive No. 18.

The negotiation team comprises of:

a) *Primary Negotiator*
The person who communicates with the hostage directly. He/she shall have certain skills and qualities to be an effective negotiator (refer Appendix 2).

b) *Secondary Negotiator*
The person who assists the primary negotiator and gives suggestions concerning tactics by offering advice, monitoring the negotiations and ensuring that the primary negotiator conducts the negotiation in the proper perspective.

c) *Intelligence Officer*
The person who is responsible for interviewing people and gathering as much background information as possible eg criminal history, history of mental illness or other relevant information in an attempt to supply information to the primary negotiator.

d) *Mental Health Professionals (MHP)*
The person who conducts assessments and provides information on mental health of negotiator, HTs and hostages.

e) *Religious officer*
When relevant, the person will provide religious inputs that may assist in negotiation process.

3.2 DUTIES AND RESPONSIBILITIES OF THE MENTAL HEALTH PROFESSIONALS (MHP) :

3.2.1 Profiling and assessment of HTs and hostage(s)

a. Evaluate the presence of mental disorders, personality disorders, psychological motivations and/or suicidal ideation in HTs
b. Continuous Mental State Assessment.
c. Create a psychological profiling
d. Assist the negotiation team in gathering relevant information

3.2.2 Evaluation of negotiation and management strategies

a. Listen directly in the negotiations.
b. To assist and monitor the negotiations in order to understand the dynamics of the incident and to ensure the negotiators maintain the objectivity and neutrality.
c. Communicate immediately to the negotiator when there is evidence of subtle shifts in mood, stress levels, impending violence, signs of intoxication or thought disorder of HTs.
d. Inform the negotiator immediately when there is evidence of subtle shifts in mood and increase in stress levels of the negotiator.

3.2.3 Monitoring of stress during crisis

a. Three levels of assessment :
   (i) Stress levels amongst the hostage(s) / HTs.
   (ii) Reactions of the hostages / HTs.
   (iii) Stress on the negotiators.
b. Negotiators' sources of stress :
   (i) External : conflicts with superiors over negotiation strategies and pressure for tactical interventions.
   (ii) Internal: concerns that the incident will not be resolved peacefully.
c. Failure to manage stress effectively may destabilize the situation.
d. Education, peer support and crisis debriefing is essential in dealing with negotiator stress.
e. HTs/Hostages may act in unpredictable ways if they fail in handling the stress.

3.2.4 MHPs are responsible for writing a progress report during each shift and a comprehensive handover report at the end of the shift. The final report is to be prepared as the crisis ends.

3.2.5 The National MHP Coordinator is responsible for drawing up the duty roster throughout the crisis. The rotation has to be at regular intervals to avoid mental exhaustion. A minimum of one personnel per shift is recommended.

3.2.6 Training for negotiators and MHPs :

a. Focus on basic negotiation concepts and negotiation strategies when dealing with mental health issues.

b. Develop training scenarios in which negotiators deal with individuals who are depressed, suicidal, intoxicated or psychotic.
c. Role play with simulated mentally ill HT which reflects the type of behavior and verbal responses characteristic of a particular illness may be utilized in these exercises.
d. Training sessions should be as realistic as possible involving all the relevant agencies.
e. MHP needs to be competent to assess mental state of the negotiators, HT and hostage(s). The assessment may be extended to other relevant teams if necessary. MHP is expected to make appropriate recommendation to the negotiating team throughout the negotiation process.

3.2.7 Future research into the characteristics of hostage incidents and the success of negotiation strategy.

a. The establishment of a research database on hostage incidents will assist in determining what factors influence success and failure.
b. To establish national data on HT with mental health issues and mental health consequences of the hostages without breaching confidentiality
c. Research into the effectiveness of crisis management strategies.
d. The negotiation team can use the research findings for future references.

3.2.8 To provide Psychological First Aid (PFA), debriefing and appropriate psychological support to the negotiators and hostages once crisis situation resolved.

CHAPTER 4

HOSTAGE TAKERS WITH PSYCHIATRIC DISORDERS

4.1 HOSTAGE TAKERS WITH SCHIZOPHRENIA SPECTRUM DISORDER AND OTHER PSYCHOTIC DISORDERS

Psychotic disorders are a form of major mental disorder characterized by presence of hallucinations and/or delusions, disorganization in speech and behaviour and negative symptoms. The individuals affected may experience deterioration in functioning in various domains. They may have not been diagnosed, treated or non-compliant with treatment and medications.

The combination of fear, anger, frustration and anxiety are the predominant underlying emotion in HTs which can be secondary to the primary psychotic symptoms.

The main objective is to calm down the HTs using the following techniques:

a. Calmness of the negotiator
b. Effective active listening
c. Rapport building
d. Non-judgemental

(note : *Do not expect a positive response as their actions are influenced by their symptoms and the loss of touch to the reality*)

The negotiation must be in the following manners:

a. Logical
b. Factual
c. Respectful
d. Empathy

Allow productive ventilation, but beware of the subject self-escalating himself into a rage. If this starts to happen, utilize distraction techniques i.e. changing topics that avoiding confrontation topic.

SYMPTOMS	NEGOTIATION STRATEGY
Thought Disorder i. Delusions e.g. persecutory delusions, delusion of reference ii. Disorganized speech	• Rapport, trust, honesty and empathy can be developed by allowing the HTs to explain about their belief and situation. • Identifying and addressing the content of the delusions and try to acknowledge the HT's perspective of the situation. • Do not try to convince them that their beliefs are wrong. • Do not try to change their mind and neither agree nor disagree with their delusion. • The negotiators need to balance between being too indifferent and being over inclusive. • Keep things straightforward and prioritize on solving the problems during the negotiation. Example 1 : ***Negotiator:*** Let me understand this. Your colleagues in your office have been monitoring you in an embedded cctv in your house in an attempt to blackmail you. Is that right? ***HT:*** No. You just don't get it. Why is it so hard for everybody to understand? ***Negotiator:*** I'm sorry, please explain it to me again gradually, because I want to make sure that I understand what you're telling me. ***HT:*** [Explanation given] "Okay, now do you understand? **Negotiator:** If that's what you think they're doing, it must make you feel scared and angry. I wonder if there's a way to get more information on this before anyone gets hurt.

Perceptual Disturbances Hallucinations eg Auditory i. (Derogatory in nature). The HTs are usually in a state of extreme fear and agitation in response to these hallucinations. ii. (Commanding in nature), which orders the subject to do something.	• Try to understand. • Comments should be specific and clear. Example: ***Negotiator:*** You said that the voices are always scolding and accusing you. Can you please elaborate? ***Hostage taker:*** They always talking about me and commenting what I am doing. The voices won't stop. They tell me that everyone condemns me because I am inadequate. ***Negotiator:*** I can't imagine what you're going through.I would like to help you, however, you have to tell me how I can best go about this.
Inappropriate Emotions/ Actions i. Laughing / Crying Inappropriately ii. .Having mannerism/ stereotypy movement e.g. rocking, rubbing, twisting hair.	• Avoid sudden action and gesture. • Look for space. • Avoid getting too close or staring at the HTs. • Offer assistance e.g. medication.
Other Characteristics : i. Disorientated/confused ii. Argumentative, having abnormal behaviour such as talking to himself/herself	• Constant reassurance to address fears. • To orientate

4.2 HOSTAGE TAKERS WITH DEPRESSIVE DISORDER

The HTs with depressive disorder usually have negative view and interpretation about life. Their underlying emotions are usually an extreme anger and sadness. In most cases, they want to survive. This leaves some negotiating room, because the HTs and negotiators have something to offer each other. However, depressed subjects may be feeling hopeless and suicidal and therefore especially dangerous precisely because they are not at any disadvantage by taking hostages down with them.

SYMPTOMS	NEGOTIATION STRATEGY
i. Sadness ii. Hopelessness iii. Worthlessness iv. Brooding over past event (tearful) v. Sleep/appetite disorder vi. May be situational, long-term problems vii. Recent loss viii. Suicidal, but not always ix. Self-neglect	• Begin the conversation at a slow rate and gradually pick up the speed over time. • Begin with open-ended questions and allow for long pauses before the answers come. • Ask simple, direct, close-ended questions if open-ended questions failed. • Use reflection of feelings as necessary. • Try to keep the time perspective grounded in the present if the HT begins to linger on a painful, past, and aimless future. • Discuss about present instead of past. • Avoid deep religious or philosophical issues. • Avoid getting friends of the depressed individuals to assist since their presence may escalate guilt. • Beware of sudden betterment in mood.

4.3 HOSTAGE TAKERS WITH SUICIDAL IDEATION

Primary Reason for a person wishing to commit suicide

a. Hopelessness
b. Helplessness
c. Loneliness
d. Guilt
e. Separation/Abandonment.

Negotiators should remember that the hostage-taker while holding hostages, generally wants to live. The suicidal subject generally wants to die, but the threat of suicide may be used to test reaction of the negotiator, to gain something from the situation and to manipulate events. Negotiation objectives in suicide intervention should be dispersing intense emotions. If the HTs brings up suicide, address it frankly and gently, later proceed with suicide risk assessment (refer Appendix 8).

SYMPTOMS	NEGOTIATION STRATEGY
i. Hopelessness ii. Helplessness iii. Loneliness iv. Guilt v. Separation/Abandonment.	• Show empathy • Ask about suicidality • Do further assessment if suicidality is present by asking about suicidal thoughts, intentions and plans. • Identifying the contributing factors and protective factors. • Get the HT to express his/her feelings and to think about a realistic plan. • If the HT wants to end the conversation, try to persuade the HT to:

	i. Stay on with the conversation; ii. Not harm themselves or hostages iii. Agree to a time when the negotiators can call back • Beware of sudden improvements of the depressive symptoms in HTs as this may indicate imminent suicidality and violence towards the hostages. • Beware HTs intention 'suicide by cop' (manipulating the police officers to force them to kill him). • Do not agree with HTs "final request".

4.4 HOSTAGE TAKERS WITH BORDERLINE PERSONALITY DISORDER

The key traits for Borderline Personality Disorder are a pervasive pattern of instability of interpersonal relationship, self-image, and mood, marked impulsivity and frequent suicide threat or gestures, and extreme dependence on others.

The borderline hostage situation is most likely to be relationship-based. They usually involve in barricade and domestic hostage incidents. To gain attentions from others are their main objective when making demand. This type of HTs tends to displace their hostility and dependency in their personal relationship to the negotiators. The psychiatrist/clinical psychologist need to assist the police departments in these situations.

SYMPTOMS	NEGOTIATION STRATEGY
Instability of interpersonal relationship and mood	Negotiators must handle their stress and emotional responses well
Impulsivity and frequent suicide threat	Negotiators should monitor the HT suicidal risk as he/she has high suicidal risk throughout the negotiation process
Instability of mood	Negotiator must be cautious when allowing HT to ventilate. They need to use distraction technique whenever they note that HT's anger level is rising. Negotiators must keep the HT as calm as possible by using reassuring voice and monitoring his/her emotion and minimize/ eliminate activity around the scene.
Transient psychotic symptoms	Negotiators must be alert to psychotic symptoms and, must avoid arguing with borderlines about the content of their delusions.
Overwhelmed, confused, and highly unpredictable and instability of mood	Negotiators must provide structured plan for HT by describing each phase of any planned interaction. However, flexibility in response should be maintained in view of the general mood instability of the HTs.

4.5 HOSTAGE TAKERS WITH ANTISOCIAL PERSONALITY DISORDER

Antisocial personality disorder is a pervasive disregard and violation of the rights of others associated with impulsivity and criminal behavior.

Antisocial personality is sometimes referred to as psychopaths. They are ruthless and remorseless, and are often expert at manipulating and intimidating those around them.

It is easy to recognize this type of HT by his/her narcissism, stress-free voice and attitude, high verbal skill, and frequent use of rationalization and projection to justify his/her situation. Taking chances, threatening and suicidal threats are part of their characteristics. Even though their plans are unrealistic but are convinced that they are smarter, stronger and able to escape from the scene

SYMPTOMS	NEGOTIATION STRATEGY
The influence of ego stimulation and ego threat	• Try to build rapport between negotiator and HT by matching according to race, religion, nationality, and education. • Negotiators should avoid any ego threat by cautiously choose words and actions • Avoid sharing personal information as the HT may use against the negotiator • Do not use words that imply force/mandatory e.g. must/must not do
Manipulative behaviour	Negotiators should prevent any signs of ambivalence or indecision

Conning and bullying behaviour	Be as cautious and straightforward as possible and do realize that virtually nothing he says can be taken at face value.
The antisocial personality has no conscience	Do not attempt to put HT on a guilt trip strategy
Use of rationalization and projection defense mechanism.	Play into his rationalization and projection. HT uses rationalization to excuse his criminal behavior and tend to blaming others for his situation. Example: *"I just intended to rob the bank. The police responded too fast and forced me to take hostages as an act of self-defense."*
Self-centeredness and reckless behaviour	Extended time does not provide safety to the hostages. HT will never form any emotional attachment to his hostages. Keep the HT busy as they need to be in control and when they are occupied with discussion, they are less likely to injure hostage
Impulsivity	The authorities need to provide as much external structure that they are willing to maintain under pressure from the hostage-taker.

Antisocial Personality Disorder is strongly associated with substance use disorder (Gerstley et al.,1990,Kessler et al., 2005,Goldstein et al.,2017). In the Epidemiological Catchment Area (ECA) study, when men with and without antisocial personality disorder were compared, those with antisocial personality disorder were three and five times more likely to misuse alcohol and illicit drugs (Robins et al., 1991). For further assessment on drug/alcohol withdrawal symptoms refer Appendix 9.

CHAPTER 5

POST HOSTAGE CRISIS MANAGEMENT

POST HOSTAGE CRISIS MANAGEMENT

During the negotiation process, the anger and hostility experienced by the negotiators towards the HT or other team members cannot be expressed openly. Furthermore, negotiator often feels such negative emotions as guilt and self-blame when the negotiation is not resolved successfully. If negotiators fail to acknowledge their negative feelings, then these feelings are internalized, remain unresolved and may be expressed in entirely inappropriate ways at work or at home. Even in successful resolutions, there may be emotions or concerns that the team would want to abreact. Similarly, the behaviours and reactions of the hostages need to be assessed for any psychological traumatic effects following their release.

Thus, the negotiators, hostages and other team members may require the process of debriefing by MHPST. The aims of the debriefing are to alleviate distressing effects from the incident, prevent subsequent development of any negative emotional sequelae or psychiatric symptoms, and restore the negotiators or hostages to pre-incident level of functioning as soon as possible (Randall et al. 1997). However, it is important to note that debriefing is not a substitute for psychotherapy. It is generally conducted immediately or shortly after the incident (Strentz. 2017), based on a step-by-step phase as shown below:

Debriefing Phases	Description
Introduction	Role of MHPST and purpose of session
Fact finding	Elicit information about the incident
Thought	Describe thoughts before, during and after the incident
Reaction	Express feelings about the incident
Symptom	Relate physical and psychological symptoms experienced during the incident
Educational	Normalize reactions, provide education on psychiatric symptoms and coping strategies

In post-debriefing, the MHPST should identify and refer those who require further review or assessment to a psychiatrist or clinical psychologist in order to deal with any potential emotional or psychological complications from the incident. Hostage takers with mental illness may be evaluated by the forensic psychiatrist after commencement of the legal proceedings.

CHAPTER 6

LOG, REPORTS AND NEGOTIATOR'S VISUAL BOARD

6.1 NEGOTIATOR'S LOG

Negotiator's log is important. It also called "Decision log". The key function of this log is to show important events in negotiation process. These include:

a. To chart all the events including time and the people involved.
b. To register the names of persons that comes to the negotiation cell and their contributions.
c. To record the decision making process and the rationale behind it.
d. Charting all relevant details including instructions from the co-coordinator and others.

Other characteristics of the log are;

a. The log is not intended to be a synchronous and literal record of everything that is said during negotiations;
b. It should include synopsis of progress; and
c. It should also be used to brief incoming negotiators and coordinators.

A team change may take place when the negotiator leaves the cell for an extended period, during the conclusion of negotiations. In this case, the log should be read and signed by the person of per concerned. Additions can be made to the log as long as they are initialled, timed and dated and do not appear as belated insertions.

A twin tape cassette machine linked to the field telephone or conventional telephone is the most reliable and best method of recording. If it is not feasible, it is up to NSC to decide the most appropriate method for this purpose.

Officer should make a separate note in their pocket whenever it is not possible to record the comments due to logistic reasons. It should be then placed in a binder during the siege for the use of the coordinator. The original, or top copy of the log, should either be retained by the lead negotiator as his/her original note or given to the chief investigator as a document.

Though all activities are recorded in the log, the negotiator must submit an after-negotiation activity report to the On-scene Commander. Said report shall become part of the after incident report to be submitted by the On-Scene Commander.

6.2 SCREENING TOOLS AND RELEVANT LOGS FOR PSYCHIATRIST

Screening tools and relevant logs for psychiatrist must be simple and not elaborative. It needs to be observer rated as much as possible except for the post incident questionnaire (if any). All information that is available from other logs will be used to fill up the screening tools wherever applicable.

Bear in mind that psychiatrist will never be able to be near to the situation and can only gauge as many information as possible from observation and counter interview with relevant people who has direct access to the situation. In view of this, all forms are a mixture of demographic/physical details as well as signs and symptoms for psychiatrists to make a rough assessment of what is happening to all the people involved.

The forms may include:

Appendix 3 Negotiator's Visual Boards:
This information will be available in the command center

Appendix 4 Hostage Taker Profile Form
Part of the information will be gathered by the negotiating team and may be useful for general view of the said hostage

Appendix 5 Hostage Taker History & Behavioral Form

Appendix 6 Hostage Profile Form

Appendix 7 Hostage History & Behavioral Form

Appendix 8 SADPERSONS Suicide Risk Assessment for Hostage Taker/Hostage (Pre & Post Crisis)

Appendix 9 Checklist of Possible Drug/Alcohol Withdrawal Symptoms (Observable Physical Symptoms)

Appendix 10 List of Useful Psychiatric Information to be used by Negotiators

Appendix 11 Negotiator's Mental State Examination Status

Appendix 12 Psychological First Aid Worksheet for Care Provider (Post Hostage Crisis Management: Form I & II)

Appendix 13 Hostage's Current Needs (Form 2)

6.3 REPORTS

i. It is use during the situation and for the purpose of post mortem.

ii. The report will be divided into two(2):

   a) The first report will be used by other non-psychiatric team members which consist of immediate impression of hostage(s) and hostage takers current mental state that can be used to the advantage of the negotiating team members. It should include recommendation of useful approach to the hostage takers in hastening the negotiating process

   b) Second report will be a detailed report of the whole event from psychiatric point of views with recommendation of future events

iii. In essence, reports from psychiatrist to be used by other team members must be prompt, up to date with minimal psychiatric jargons to avoid confusion among the other team members.

iv. Reports for future usage must be in detail with possible verbatim, if necessary, in order for us to improve training module and crisis situation approach.

APPENDIX

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

APPENDIX 1

DOS AND DON'TS WHEN NEGOTIATING

DOS WHEN NEGOTIATING	DON'TS WHEN NEGOTIATING
Be empathetic, reassuring, and convincing	Talk too much
Control your own emotions and voice	Be argumentative and pushy
Keep the HT(s) talking.	Use trigger words
Keep the HT(s) in decision-making mode	Get angry
Understand any demands.	Be defensive
Be sensitive to personal and cultural issue involving pride and respect.	Make promises
Always work through deadlines	Get caught in a lie
Always ask to speak to those being held. Seek proof of life.	Allow third party negotiating (wife, clergy, friends)
Work with a partner who can help with prompts, and make notes.	Trade places with a hostage
Take any threats seriously	Set deadline Ask for demand, they may not have any

APPENDIX 2

QUALITIES OF NEGOTIATORS:

The key skills that are looked for in a negotiator are as follows:

1.1 Communication

The negotiator should be able to speak clearly and concisely, build rapport and trust easily and comfortably with various types of people, have good listening skills and the ability to stay calm and take charge of conversations.

1.2 Cognitive Skills

The negotiator should be mentally agile, astute, logical, rational and flexible, with the ability to identify motives and critical issues and anticipate outcomes while developing creative strategies.

1.3 Relationships with others

The negotiator must be able to work cooperatively as part of a team, is genuinely caring about others, able to show empathy and socially confident.

1.4 Professional Competence

Has good operational background and wide experience, tactically aware of the CRT and assault team, as well as being professionally committed to the ethics of negotiations.

1.5 Personal Qualities

The negotiator should have good emotional control and coping skills, always remaining calm, patient, resilient and persistent even when facing failure or aggression. Furthermore, a negotiator must be confident without being arrogant, able to accept responsibility and must be physically and mentally fit.

APPENDIX 3

NEGOTIATOR'S VISUAL BOARDS

NEGOTIATOR'S VISUAL BOARDS	
HOSTAGE TAKERS	HOSTAGES
WHO ARE THEY?	WHO ARE THEY?
HOW MANY?	HOW MANY ARE THERE?
WHY THEY ARE DOING THIS?	HOW MANY ARE INJURED?
	HOW MANY ARE CHILDREN?
	HOW MANY ARE WOMEN? IS THERE ANY PREGNANT LADY INVOLVED?

APPENDIX 4

HOSTAGE TAKER PROFILE FORM

HOSTAGE TAKER PROFILE FORM								
Incident					Incident			
Hostage						Number		
Occupation								
National	Race	Sex	Height	Weight	Hair	Facial Hair		
Eyes Description (including colours, accessories etc)								
Clothing (Head to Toe)								
Underlying Medical Problem (Please list down)				Yes		No		

APPENDIX 5

HOSTAGE TAKER HISTORY & BEHAVIORAL FORM

HOSTAGE TAKER HISTORY & BEHAVIORAL FORM						
Name					Date/Time	
National	Race	Sex	Weight	Height	Hair	Face
General Behavior (as observed)						
Underlying Medical/Psychiatric Condition						
Current Medication (Dosing & Frequency)						
Any Disabilities (Please List Out)						
Any Special Needs						
Emergency Contact						

APPENDIX 6

HOSTAGE PROFILE FORM

HOSTAGE PROFILE FORM							
Incident				Date/Time			
Name					Number		
Relationship with Hostage							
Occupation							
National	Race	Sex	Height	Weight	Hair	Facial Hair	DOB
Eyes Description (including colours, accessories etc)							
Clothing (Head to Toe)							
Underlying Medical Problem (Please list down)				Yes		No	
Past History of Aggression							
Drug History							
Any Weapons							
Past Criminal History and Imprisonment							
Group Association							
Current Address							
Emergency Contact Number							
Next of Kin (Name/Relationship/Current Location)							

APPENDIX 7

HOSTAGE HISTORY & BEHAVIORAL FORM

HOSTAGE HISTORY & BEHAVIORAL FORM						
Name					Date/Time	
National	Race	Sex	Weight	Height	Hair	Face
General Behavior (as observed)						
Any Abnormal Movement/Posture						
Speech						
Suspect/Hostage Relationship	Domineering/Aggressive/Suspicious/Dangerous					
Suspect/Negotiator Relationship	Suspicious/Cooperative/Evasive/Intimidating/ Threatening					
Underlying Medical/Psychiatric Condition						
History of Suicide Attempt/DSH						
Current Medication (Dosing & Frequency)						
Current Follow Up (Settings & Date)						
Any Disabilities (Please List Out)						
Any Special Needs						

APPENDIX 8

SADPERSONS SUICIDE RISK ASSESSMENT OF HOSTAGE TAKER/HOSTAGE (During and/or Post Crisis)

SADPERSONS SUICIDE RISK ASSESSMENT OF HOSTAGE TAKER/HOSTAGE (During and/or Post Crisis)	
Name :	Date/Time
Factors	Points
S-Sex (Male)	1
A-Age (<19 years or, >45 years old)	1
D-Depression or Hopelessness	2
P-Previous Suicide Attempts	1
E-Excessive Alcohol or Drug Use	1
R-Rational Thinking Loss	2
S-Separated, Divorced or Widowed	1
O-Organized or Serious Attempt	2
N-No Social Support	1
S-Stated Future Intent	2
Score	
Score 6-8: Full Psychiatric Emergency Evaluation/Treatment	
Score 9 or Greater: Immediate Psychiatric Hospitalization	
Source: Hockberger RS, Rothstein RJ. Assessment of suicide potential by non-psychiatrists using the SAD PERSONS score. J Emerg Med 1988 Mar-Apr; 6(2):99-107.	

APPENDIX 9

CHECKLIST OF POSSIBLE DRUG/ALCOHOL WITHDRAWAL SYMPTOMS (OBSERVABLE SYMPTOMS)

CHECKLIST OF POSSIBLE DRUG/ALCOHOL WITHDRAWAL SYMPTOMS (OBSERVABLE SYMPTOMS)	
Name	
Date/Time	
SUBSTANCE	
Alcohol	Nausea/vomiting, tremors, sweating, anxious, agitation, perceptual disturbances, disorientation
Opioid	Tremors, sweating, yawning, restlessness, anxiety/irritable, runny nose/tearing
Cannabis	Agitation, anger, anxiety, violent outburst, shakiness, yawning, hiccups, nausea, diarrhoea, chills, muscle spasm, stomach pain, stuffy nose
Stimulants	Irritability, sleepiness, restlessness, perceptual disturbances
GENERAL COMMENTS & RECOMMENDATION	

APPENDIX 10

LIST OF USEFUL RECOMMENDATIONS FOR NEGOTIATOR DURING NEGOTIATION

LIST OF USEFUL RECOMMENDATIONS FOR NEGOTIATOR DURING NEGOTIATION
Time/Date:
Hostage Takers
Hostages

APPENDIX 11

NEGOTIATOR'S MENTAL STATE EXAMINATION STATUS

NEGOTIATOR'S MENTAL STATE EXAMINATION STATUS	
Name	Date/Time
GENERAL APPEARANCES Alertness, distractibility, grooming/hygiene	
ENGAGEMENT WITH OTHERS Eye contact, Cooperation, Transference	
MOTOR ACTIVITY LEVEL Normal, hypo/hyperactive, agitated	
SPEECH Expression, Comprehension, Form	
EMOTION Mood, Affect, Affect Range/ Intensity, Affect Fixity, Affect Congruence	
THOUGHT CONTENT Content, Risk, Delusion	
INSIGHT & OTHER Insight, Judgment, Impulse Control, Motivation	
COGNITIVE DISTORTIONS All-or-Nothing Thinking, Over-generalizing, Negative Mental Filter, Jumping to Conclusions etc	
RECOMMENDATION	

APPENDIX 12

PSYCHOLOGICAL FIRST AID WORKSHEET FOR CARE PROVIDER (POST HOSTAGE CRISIS MANAGEMENT): Form I & II

Form I - HOSTAGE'S CURRENT NEEDS							
HOSTAGE SURVIVOR'S NAME				Date/Time			
BEHAVIOR		EMOTIONAL		PHYSICAL		COGNITIVE	
Extreme disorientation		Acute Stress Reaction		Headache		Inability to accept/ cope with death of loved one(s)	
Excessive usage of drug/ medication		Acute Grief		Abdominal pain		Distressing dreams or nightmares	
Isolation/ withdrawal		Sadness/ Tearfulness		Sleep Difficulty		Preoccupation with death/ destruction	
High Risk Behavior		Irritability/ Anger		Difficulty Eating		Difficulty making decisions	
Regressive Behavior		Fearful/ Anxious		Worsening Health Condition		Difficulty remembering	
Separation Anxiety		Despair/ Hopelessness		Fatigue		Difficulty concentrating	
Violent Behavior		Guilty/ Shame		Chronic Agitation		Intrusive thoughts/ image	
Maladaptive coping				Emotional Numbness			
RECOMMENDATION							

APPENDIX 13

HOSTAGE'S CURRENT NEEDS (FORM 2)

HOSTAGE'S CURRENT NEEDS (FORM 2)	
Check the boxes corresponding to difficulties the survivor is experiencing	
	Past or pre-existing trauma/psychological problems/substance abuse problems Injured as a result of the disaster
	At risk of losing life during the disaster
	Loved one(s) missing or dead
	Financial concerns
	Displaced from home
	Living arrangements
	Lost job or school
	Assisted with rescue/recovery
	Has physical/emotional disability
	Medication stabilization
	Concerns about child/adolescent
	Spiritual concerns
	Other :
Please list out your immediate management & referral	

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ABBREVIATION

ABBREVIATION

CMT	Crisis Management Team
GGK	Grup Gerak Khas
HT	Hostage Taker
MAF	Malaysian Armed Force
NSC	National Security Council
NT	Negotiation Team
PASKAL	Pasukan Khas Laut
PASKAU	Pasukan Khas Udara
PGK	Pasukan Gerak Khas
RMP	Royal Malaysia Police
TCC	Terrorism Control Committee
PFA	Psychological First Aid
CRT	Crisis Response Team
FBI	Federal Bureau of Investigation

GLOSSARY

Ego stimulation: increase the sense of self importance
Ego threat: any factor that tends to diminish a person's opinion of him/herself

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