Crisis Negotiation Team Policy

Integration of Behavioral Health Advisors

Standards and Best Practices for Crisis Negotiation Teams

Board for Advocacy, Standards and Excellence (BASE) Project

National Tactical Officers Association

Version 1.0 - Published April 2026

COPYRIGHT

CONTENTS

EXECUTIVE SUMMARY

Behavioral Health Advisor Integration into Crisis Negotiation Teams

Purpose

This policy establishes best-practice standards for integrating Behavioral Health Advisors (BHAs) into Crisis Negotiation Teams (CNTs) to support the safe, ethical, and effective resolution of critical incidents. It provides clear guidance on role definition, authority, information-sharing boundaries, training, deployment, and accountability.

Operational Rationale

Crisis negotiation is a high-risk, time-compressed function requiring disciplined communication, behavioral insight, and coordinated decision-making. Behavioral Health Advisors enhance CNT operations by providing real-time behavioral analysis, communication strategy support, and risk-informed consultation to negotiators and command, without assuming a clinical or treatment role.

When properly integrated, BHAs:

- Strengthen negotiation strategy and message discipline
- Improve understanding of subject behavior, stress responses, and escalation risks
- Support ethical and legally defensible decision-making
- Reduce role confusion and liability exposure
- Improve outcomes for persons in crisis, responders, victims, and the community

Core Principles

This policy is built on the following principles:

- Preservation of life through communication and de-escalation
- Clear separation between operational advisory roles and clinical treatment
- Unified command and disciplined information flow

- Ethical, lawful, and role-appropriate use of behavioral expertise
- Accountability through training, documentation, and review

Role Clarity

- Behavioral Health Advisor (BHA) is an operational role within the CNT.
- BHAs provide consultation and analysis; they do not conduct therapy, make diagnoses, or take independent tactical action.
- BHAs operate under CNT command and leadership during incidents.
- A single-role rule applies: individuals may serve as either a negotiator or a BHA during an incident, but not both.

Legal & Risk Management

The policy establishes safeguards to:

- Prevent the creation of unintended clinician–patient relationships
- Define lawful information-sharing boundaries
- Address confidentiality, disclosure, and documentation risks
- Ensure compliance with applicable laws and professional standards

Jurisdiction-specific legal references (e.g., U.S. privacy or disclosure laws) are identified as examples, with agencies directed to apply applicable local, provincial, or national law.

Implementation

The policy outlines standards for:

- Selection and vetting of qualified personnel
- Required training and ongoing readiness
- Activation and deployment procedures
- Information handling and documentation
- Post-incident review and quality assurance

Agencies may adopt this policy in full or use it as a framework to develop or refine local CNT behavioral health integration standards.

Intended Use

This document is designed for:

- Law enforcement executives and command staff
- Crisis Negotiation Team leaders
- Legal and risk-management review
- Agencies seeking to formalize or strengthen behavioral health integration within CNT operations

CRISIS NEGOTIATION TEAM POLICY: INTEGRATING MENTAL HEALTH PROFESSIONALS

1. Purpose & Philosophy

This policy affirms the Department's commitment to the safe resolution of critical incidents through communication, de-escalation, and the preservation of life. Crisis negotiation is a core public-safety function that relies on structured communication, behavioral insight, and coordinated decision-making under high-risk conditions.

Integrating Behavioral Health Advisors (BHAs) into the Crisis Negotiation Team (CNT) strengthens negotiation strategy by providing behavioral analysis, communication guidance, and risk-informed consultation to command and negotiators. When appropriately selected, trained, and deployed, BHAs enhance operational effectiveness, support ethical decision-making, and improve outcomes for persons in crisis, victims, responders, and the community.

This policy establishes standards for the selection, vetting, training, deployment, supervision, and accountability of Behavioral Health Advisors assigned to support CNT operations.

2. Jurisdictional Applicability Notice

This policy establishes operational and ethical best-practice standards intended for use across diverse jurisdictions. Certain legal references and statutory examples (e.g., HIPAA, 42 CFR Part 2, Duty to Warn/Protect laws) are jurisdiction-specific. Agencies operating outside the United States should substitute applicable national, provincial, territorial, or local laws and professional regulations governing privacy, disclosure, professional duties, and liability.

3. Scope & Applicability

This policy applies to all sworn and nonsworn personnel assigned to, supporting, or commanding CNT operations; to attached Mental Health Providers (MHPs) (employees, contractors, or partner-agency clinicians); and to allied tactical units (e.g., SWAT/SRT) when CNT is activated.

4. Authority & Governance

- The CNT/SWAT Commander has tactical/operational authority over the BHA during incidents.
- The BHA operates within professional ethics and licensure and will not independently direct police tactics or conduct clinical treatment while acting in the advisor role.
- The Negotiations Team Leader (NTL) synchronizes all BHA inputs with the negotiation strategy.

5. Roles & Responsibilities

5.1 Behavioral Health Advisor (BHA)

- Provide rapid behavioral assessment and working hypotheses about risk, motivation, stressors, and likely pathways to resolution.
- Advise on communication strategy (tone, pacing, hooks, triggers, time use), threats of suicide/violence, and stabilization tactics.
- Assist with third-party intermediary (TPI) selection, preparation, coaching, and risk-screening; draft/verbalize TPI scripts when appropriate.
- Support interviewer(s) for collateral contacts (family, providers, probation, etc.) and synthesize relevant information.
- Collaborate with Intel/Scribe to maintain a behavioral timeline; flag escalators/de-escalators.
- Participate in huddles/briefings; provide succinct recommendations (1–3 “most likely to help” actions).
- Post-incident: provide structured after-action insights.
- Maintain OBN; ensure no diagnostic labels are recorded unless already confirmed by reliable sources; avoid therapy or treatment within the operational role.
- Should the BHA also serve as a Negotiator on the team, they are to serve in one role, and one role only, throughout the duration of an incident.

5.2 Negotiations Team Leader (NTL)

- Integrate BHA inputs into the Behavioral Change Stairway and negotiation plan; manage information flow and priorities.
- Ensure all BHA communications to or with the subject are routed through the coach: no direct BHA-to-subject contact unless explicitly authorized by the Incident Commander (IC).

- Coordinate BHA participation in training and exercises; evaluate BHA performance.

5.3 Incident Commander/Tactical Commander

- Consider BHA recommendations in overall risk decisions (time, action, resources).
- Ensure BHA is briefed on safety perimeters, comms, and PPE; authorize any exceptions (e.g., in-person TPI coaching near an inner perimeter).

6. Selection & Vetting of BHAs

Minimum Qualifications

- Master's degree or higher in a mental health discipline with a current state/provincial license in good standing, and practicing under own license.
- Over three years post-licensure clinical experience with crisis/forensic, emergency, or acute psychiatric populations (or equivalent).
- Ability to work in a Critical Incident Command structure; excellent written/oral briefings under time pressure.
- No disqualifying conflicts of interest; background check (department and Criminal Justice Information Services (CJIS) compliance) and confidentiality agreement signed.

Additional Training/Experience

- Prior law-enforcement collaboration (CIT, mobile crisis, co-responder, hospital psychiatric emergency services/emergency departments (PES/ED).
- Completion of an approved 40-hour Basic Crisis Negotiations course (or equivalent CNT-specific curriculum).
- Training in suicidal/homicidal risk, threat assessment, trauma, substance use, and developmental disabilities.

Appointment

- The Agency Executive or Designated Appointing Authority appoints BHAs upon recommendation of the CNT Commander.
- Appointment status (employee/contractor/partner-agency) and indemnification are documented in an MOU/MOA or contract (see Appendix A).

7. Training & Readiness

- **Initial:** Basic Crisis Negotiations (≥40 hours); Department CNT orientation (structure, communications, safety); legal brief (information sharing, Protected Health Information (PHI), substance-use confidentiality laws, duty to warn/protect, records management, tactical familiarization, scenario labs, etc.).
- **Ongoing:** Quarterly CNT drills including BHA participation; annual refresher (≥8 hours) on suicidal crises, psychosis, neurodiversity, substance use, veteran-specific issues, and family dynamics; periodic cross-training with mobile crisis/co-responder partners.
- **Exercises:** When feasible, at least one CNT/SWAT exercise per year with BHA embedded.

8. Activation & Deployment

- **When to activate:** Any CNT activation (e.g., hostage, barricade, suicidal/jumper, high-risk warrant standoff, manhunt with contact potential) should include a BHA when feasible or at the discretion of the CNT Commander.
- **Location:** The BHA works from the CNT operations area/NOC; proximity to the inner perimeter only with IC approval.
- **Communications:** The BHA maintains communication with the CNT radio/talk group. All recommendations/feedback regarding the primary's communication with the subject should be provided to the coach.

9. On-Scene Procedures

- **Briefing:** Receive concise intel package (subject identity, history, threats, weapons, precipitating events, recent losses/stressors, known clinicians/medications, developmental/cognitive notes).
- **Incident Cadence:** Deliver initial advisory as soon as information is available; update every 60–90 minutes or upon a major change.
- **TPI protocol:** Screen TPIs for safety, alignment, and messaging; coach using structured scripts; monitor emotional bandwidth; terminate TPI use if counterproductive.
- **Do/Don't for BHA:**
  - Do: advise, analyze language, suggest openings and avoiders, shape time use, and assist with dignified "outs."
  - Don't: diagnose on scene, promise services or immunity, direct tactics, or independently contact the subject, family, TPI or media.

10. Information Sharing, Privacy, and Records

- **Operational role (not treatment):** While embedded with CNT, the BHA functions as an operational advisor, not a treating clinician. No patient-provider relationship is created with the subject, TPIs, or members.
- **Consent-first approach:** Seek subject consent for collateral information whenever feasible (e.g., phone consent recorded by scribe).
- **Permissible disclosures without consent:** When immediate safety is at stake, the BHA may advise the IC on what information a covered entity may lawfully share to avert a serious and imminent threat, consistent with federal/state/provincial law.
- **Substance use records (SUD records):** If information originates from a federally assisted Substance Use Disorder program (42 CFR Part 2), disclosures are highly restricted; consult Legal/Policy before requesting/using such records operationally.
- **Duty-to-protect/warn:** If, during CNT operations, a credible, specific threat to an identifiable person or the public is learned through professional channels, the BHA will notify the IC/NTL immediately for appropriate action consistent with state/provincial law.
- **OBN handling:** OBNs (Operational Behavioral Notes) are retained with the CNT incident file as operational records; the BHA does **not** create clinical files in this role. OBNs should avoid language that could be construed as diagnostic conclusions or treatment recommendations, even when such conclusions appear obvious.
- **Data minimization:** Record only information necessary for operational decisions; avoid speculative diagnoses and protected health information that is not decision-relevant.

11. Safety & Logistics

- **PPE & identification:** The BHA wears agency-issued ID and appropriate personal protective equipment (PPE) and adheres to perimeter and staging rules. Ballistic helmet and vest should be available as needed.
- **Wellness safety:** The NTL monitors BHA workload/fatigue; rotation follows the same rest standards as negotiators.
- **Scene discipline:** No personal devices in the communication chain; preserve evidence; maintain radio discipline.

12. Post-Incident Actions

- **Hot wash:** As soon as feasible, the BHA supports a factual defusing for CNT/SWAT/first responders, as requested by command. The BHA will attend the hot wash but will not lead it.
- **Operational debrief:** The BHA should participate in operational AAR within 7–14 days; provide lessons learned and training recommendations. The BHA will attend the operational debrief but will not lead it.

13. Ethics, Conflicts, and Boundaries

- BHAs must disclose and avoid dual relationships (e.g., current/previous therapy with subject/family).
- BHAs may not solicit clients or provide clinical services to involved subjects unless, in extreme circumstances when no other providers/resources are available and delay would reasonably increase the risk of harm, such services are approved by Legal/Command to avoid conflicts.
- BHAs maintain professional standards and mandatory reporting obligations (abuse/neglect) consistent with the law.

14. Program Administration & Quality Assurance

- **Agreements:** Maintain updated MOU/MOA with partner behavioral health agencies, specifying scope, indemnification, supervision, equipment, and availability.
- **Metrics:** Agencies may track outcome metrics, including BHA integration, consistent with local reporting requirements and privacy laws (e.g., time to surrender, use-of-force incidents, injuries, linkages to care, complaints, negotiator fatigue markers).
- **Review:** The BHA and CNT Commander should conduct an annual review of cases to ensure adherence and incorporate findings into training.
- **Roster & coverage:** Maintain an on-call BHA roster with a minimum of two clinicians; ensure surge capacity for protracted events.

15. Coordination with Other Specialized Responses

- The BHA should coordinate with CIT, Mobile Crisis, Co-Responder Teams, and community hotlines. Use them for upstream prevention and downstream handoff while preserving CNT command unity during critical incidents.

16. Legal & Risk Notes (Summary & Expanded Guidance)

Intent: This section clarifies legal authorities, risk limitations, information-sharing boundaries, and operational safeguards for the use of a Behavioral Health Advisor (BHA) during CNT operations. It supplements, not replaces, federal/state/provincial law, professional ethics, or Department policy.

16.1 Operational Guidance Only – No Treatment Relationship

- The BHA serves *strictly* as an operational advisor, not as a clinician providing assessment, diagnosis, or treatment.
- No therapist–patient relationship is created with the subject, TPIs, family members, negotiators, or officers at any time during operations.
- All behavioral insights are considered operational intelligence, not clinical documentation.
- Any advice provided is based on good-faith professional judgment under time-compressed field conditions and does not constitute clinical care.

16.2 Information-Sharing Framework (HIPAA, 42 CFR Part 2, State Law) *US ONLY

HIPAA (45 CFR §164.152 J–K: Emergency Exceptions)
The BHA may assist CNT leadership by clarifying what health information a covered entity may disclose without consent when:

- A *serious and imminent threat* exists to life, safety, or public welfare (subsection J);
- Information is necessary for law-enforcement purposes, such as locating a suspect, identifying a fugitive, preventing harm, or supporting an active operation (subsection K).

Key rule: HIPAA does not restrict what law enforcement may share internally, only what healthcare providers may disclose to law enforcement. The BHA advises command but does not independently request or receive protected data unless lawfully permissible.

42 CFR Part 2 (Substance Use Disorder Records)

- Part 2 is far more restrictive than HIPAA.
- Records from “federally assisted Substance Use Disorder treatment programs” cannot be disclosed to CNT even in an emergency without explicit written consent or a court order, with very narrow exceptions.
- Before requesting any such records, the BHA will consult Legal.

- Any information unlawfully obtained must not be used operationally.

Agencies outside the United States should consult applicable national or provincial laws governing confidentiality in substance use treatment, which may impose similar or stricter limitations.

State Law Disclosures (Duty to Warn/Duty to Protect)
If the BHA learns of a specific, credible threat toward an identifiable person or group, whether through professional channels or on-scene communications, the BHA must immediately notify CNT Command so that legally mandated protective actions can be taken.

16.3 Good-Faith Reliance & Liability Protection

- The BHA operates in an advisory capacity only and is not responsible for the subject's tactical outcomes or decisions.
- Recommendations are made in good faith based on available information and accepted crisis-intervention principles.
- Final decisions regarding tactics, time, action, and resolution rest solely with the Incident Commander and CNT chain of command.
- The BHA is protected by applicable Good Samaritan, qualified immunity, or contractual indemnification provisions, as outlined in state/provincial law and the Department's MOU(s).

16.4 Documentation Requirements & Protections

Operational Behavioral Notes (OBN)

- OBNs are *operational documents*, not clinical records.
- Notes should be succinct, decision-relevant, and free of diagnostic labels unless previously documented by credible sources.
- No psychotherapy, treatment suggestions, or clinical formulations should be recorded.
- OBNs are retained with the CNT incident file consistent with Department retention schedules.

Sensitive Information Handling

- Use *data minimization*: document only what is necessary for CNT decision-making. Do not store:
  - Unverified diagnoses
  - Full medical histories
  - Provider-specific treatment plans
  - Substance use information regulated by Part 2

- All handling complies with departmental privacy policy and any applicable MOU regarding information security.

16.5 Third-Party Intermediary (TPI) Screening – Legal Considerations

- The BHA assists with risk screening, emotional stability assessment, and coaching, but must avoid clinical language that implies treatment.
- TPI involvement must consider:
  - Voluntary participation
  - Safety risks and potential trauma
  - Whether the subject has restraining orders or protections in place that legally prevent contact
- All TPI contacts must be coordinated through CNT command and documented in accordance with departmental policy.

16.6 Appointment, Authority, & Legal Approval

- The appointment of BHAs (employee, contractor, partner-agency clinician) requires written legal approval and must specify:
  - Scope of duties
  - Reporting structure
  - Indemnification
  - Information-sharing limitations
  - Equipment/PPE authorization
  - Role during multi-jurisdictional operations

- The BHA must sign a **Confidentiality and Information-Use Agreement** before operational deployment.

16.7 Malpractice Insurance Requirements

Agencies must clearly define:

- Whether malpractice coverage is provided by the agency, the clinician, or a combination.
- Any required tail coverage, limits of liability, or exclusions.
- Whether coverage extends to CNT training, ride-alongs, or mutual-aid deployments.

Recommended Best Practice:

- The agency maintains primary coverage for field operations work.
- The BHA maintains its own professional malpractice insurance for all non-CNT clinical duties.

16.8 Memorandums of Understanding (MOU)

MOU for Access to Medical or Behavioral-Health Records

- Defines what information may be shared during emergencies, consistent with Protected Health Information (PHI) and state/provincial law.
- Specifies who approves requests, how information is routed, and how records are logged or audited.

MOU for Law-Enforcement–Sensitive Information

- Clarifies what operational details may be shared with partner agencies or clinics.
- Ensures clinicians with dual roles understand restrictions regarding:
  - Case intelligence
  - Tactical plans
  - Criminal investigations
  - Confidential informant information
  - Juvenile information
  - Sealed or expunged records

These MOUs protect both the Department and external clinicians from improper disclosure.

16.9 Legal Consultation Requirements

The BHA or CNT Commander must consult Legal when:

- A provider is asked for information that may fall under Protected Health Information (PHI), emergency exceptions or Part 2 restrictions.
- The Department considers releasing information to clinicians or TPIs.
- There is uncertainty about whether a threat qualifies for Duty to Warn/Protect.
- A post-incident review identifies potential liability concerns.
- A clinician's dual role creates a conflict-of-interest risk.

16.10 Subpoenas, Testimony, and Legal Consultation

Notification & Coordination

- If the BHA receives a subpoena, court order, deposition notice, or request for testimony regarding CNT operations, it must promptly notify:
  - The CNT Commander.
  - The Department's Legal Unit.
  - Their own employer/agency legal counsel, if applicable.

Scope of Permissible Testimony

- Because the BHA does not operate as a treating clinician during CNT deployments, their testimony is generally limited to:
  - Operational observations.
  - Behavioral assessments made for tactical purposes.
  - Decision-support advice provided to CNT leadership.
- The BHA should not provide:
  - Clinical opinions, diagnoses, or treatment recommendations, unless they existed prior to the incident in a separate clinical capacity.
  - Speculation about the subject's mental illness, competency, or long-term prognosis unless substantiated by verified information.
- If a subpoena appears to seek records protected under Protected Health Information (PHI) or under state/provincial confidentiality statutes, Legal must be consulted immediately before any response.

Consultation With Legal Counsel

- The BHA has the right — and in some circumstances the obligation — to consult with:
  - Department legal counsel for matters involving operational conduct;
  - If applicable, their own agency/organization's attorney for issues involving licensure, ethics, malpractice, or dual-role considerations.
- The Department will cooperate with the BHA's legal team when testimony involves operational confidentiality, use-of-force reviews, or sensitive tactical information.

Handling of Operational Behavioral Notes (OBNs)

- OBNs are considered operational records and may be subject to discovery.
- Prior to production or testimony, Legal will review OBNs to determine:
  - What can be released?
  - What must be redacted?
  - What may require a protective order due to law enforcement sensitivity?
- The BHA must not independently release OBNs or any incident-related notes without Department Legal approval.

Conflicts Between Subpoena and Confidentiality Law

- The BHA must wait for Department Legal to file a motion to quash, modify, or seek judicial clarification if a subpoena demands information that conflicts with:
  - Protected Health Information (PHI) restrictions.
  - 42 CFR Part 2 protections. (US only)
  - MOU confidentiality provisions.

Depositions & Testimony Preparation

- Prior to testimony, the BHA is provided the same legal support and consultation as all other team members.
  - Clarify what is legally permissible to discuss.
  - Review the limits of their operational role.
  - Ensure no statements inadvertently imply a treatment relationship.
  - Avoid speculative or diagnostic testimony beyond the BHA's operational purview.

APPENDICES

Appendix A — Definitions of Terms

Activation/Callout	The deployment of CNT and supporting tactical resources in response to a crisis requiring specialized negotiation and behavioral expertise.
Behavioral Change Stairway Model (BCSM)	A negotiation framework emphasizing active listening, empathy, rapport, influence, and behavioral change—integrated into CNT strategy and informed by BHA recommendations.
Behavioral Health Advisor (BHA)	The operational role assigned within the Crisis Negotiation Team to provide behavioral assessment, strategy consultation, third-party intermediary guidance, and post-incident advisory support.
Coach	A negotiator responsible for monitoring the primary negotiator's communication, guiding strategy, integrating BHA input, and maintaining message consistency.
Collateral Contact	An individual (family member, clinician, probation/parole officer, etc.) who is interviewed to gather historical or behavioral information relevant to negotiation strategy.
Command and Control	A design or system to provide for the interaction of the essential components and assures that all efforts are directed toward achieving a command goal. It is necessary to define lines of authority effectively, distribute power and allocate resources.
Consultant vs. Team Member	BHAs may serve under a written agreement as (a) a standing CNT member or (b) an on-call consultant. Duties are identical; administrative status may differ.
Containment	Pre-designated perimeter positions at the incident location(s) to control and contain suspect movement.
CNT Commander	The individual with operational authority over all CNT activities during an incident, including oversight of negotiators, the coach, the BHA, and all support personnel.
Crisis Negotiation Team (CNT)	A specialized team, the Crisis Negotiation Team, is responsible for developing actionable intelligence regarding any negotiations/tactical

	problems, contributing to a risk assessment, opening lines of communication with a suspect, and using active listening and bargaining techniques to negotiate a surrender.
Hot Wash	A brief, immediate, factual debrief conducted as soon as safely possible after an incident. The hot wash captures early observations and lessons learned before formal review.
Imminent Threat	A credible, immediate risk of significant harm requiring urgent action or lawful disclosure of otherwise protected information.
Incident Commander (IC)	The individual responsible for all incident activities, including developing strategies and tactics and ordering and releasing resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for managing all incident operations at the site.
Mental Health Professional (MHP)	A state/provincially licensed clinician (e.g., psychologist, psychiatrist, licensed clinical social worker, licensed professional counselor) who may be appointed to serve as a Behavioral Health Advisor, subject to agency selection, vetting, and appointment standards.
Negotiations Team Leader (NTL)	The team member who coordinates the negotiation strategy, manages information flow, integrates BHA recommendations, and supervises the negotiator-coach-scribe triad.
Operational Behavioral Notes (OBNs)	Non-clinical, incident-specific advisory notes created by the BHA for command/CNT use (distinct from clinical records).
Operational Debrief (After-Action Review – AAR)	A structured process for analyzing a particular operation or exercise, and usually includes subject matter experts or superiors, not assigned to the team, specifically tasked with identifying areas for improvement. It examines decision-making, communication strategies, behavioral insights, and recommendations for training or policy updates.
Primary Negotiator (Primary)	The designated CNT member who communicates directly with the subject during the incident.
Protected Health Information (PHI)	Individually identifiable health information or equivalent confidential health information as defined by applicable law (e.g., HIPAA in the United States; PHIA/PIPEDA in Canada).

Scribe/Intel Officer	The CNT member responsible for logging communication, timelines, and intelligence updates to support accurate strategy development.
Special Weapons and Tactics (SWAT/SRT)	Acronym for Special Weapons and Tactics team. A designated law enforcement team whose members are recruited, selected, trained, equipped, and assigned to resolve critical incidents involving a threat to public safety that would otherwise exceed the capabilities of traditional law enforcement first responders and/or investigative units.
Tactical Disengagement	A deliberate command decision to pause or alter engagement strategies to restore safety, reevaluate conditions, or regain negotiation advantage.
Third-Party Intermediary (TPI)	Family/friend/associate used strategically to influence a subject.

Appendix B — Template MOU/MOA Clauses (Behavioral Health Advisor to CNT)

- **Parties:** [Agency] and [Behavioral Health Agency/Clinician].
- **Purpose:** Provide qualified licensed clinicians as BHAs to advise CNT during critical incidents and exercises.
- **Services:** On-call availability; incident response; training participation; post-incident AAR.
- **Authority & Supervision:** BHAs operate under the IC/NTL during incidents; clinical supervision remains with the BH agency for licensure/compliance.
- **Status & Indemnification:** Specify employee/contractor/partner status, workers' comp, liability, malpractice coverage; indemnification and hold-harmless terms.
- **Confidentiality & Records:** Define OBNs as operational records; prohibit creation of clinical charts; specify lawful information sharing; address 42 CFR Part 2 restrictions.
- **Background & Vetting:** Licensure verification, background check, training prerequisites.
- **Training:** 40-hour Basic CNT within 12 months; quarterly participation in CNT exercises.
- **Equipment & Access:** ID badges, PPE, secure communications access, facility access.
- **Compensation:** Stipend/retainer and callout rates or in-kind contribution.
- **Term & Termination:** Term length, renewal, suspension for cause, and immediate termination for breaches.

Appendix C — Confidentiality & Role Acknowledgment (BHA)

A one-page form signed annually acknowledging:

- Operational advisor (non-treating) role.
- Information sharing boundaries (consent, serious-threat exceptions, mandatory reporting, 42 CFR Part 2 limits).
- No direct media interaction.
- Compliance with Department policies and lawful orders.

Appendix D — On-Scene Checklist (BHA)

- Check in with IC/NTL; obtain safety brief and communications information/capabilities.
- Receive intel packet; identify gaps; request TPI candidates.
- Provide initial advisory (risk, hooks, openings, avoiders).
- Coach negotiator on language/pace; propose next 1–2 moves.
- Screen/prepare TPIs; script and boundaries reviewed.
- Update advisory on major changes; document OBNs.
- Participate in huddles; support negotiator rest cycles.

Appendix E — Family/TPI Interview Guide (Quick Use)

- Goals: Safety, dignity, influence, credible pathways.
- Do: Validate, humanize, appeal to values/roles, offer non-shaming outs.
- Don’t: Threaten, bargain irresponsibly, litigate past harms, or overpromise outcomes.
- Script frame: (1) Affection/concern; (2) Specific ask tied to safety; (3) Future-focused commitment; (4) Clear boundary if behavior escalates.

Appendix F — Information-Sharing Decision Tree (Summary)

1. Do we have subject consent? If yes → share relevant minimum necessary.
2. Imminent/serious threat? If yes → consider disclosures consistent with law/policy.
3. Is the information from a SUD program (42 CFR Part 2)? If yes → do **not** access/disclose without Part-2-compliant consent or court order; seek Legal.
4. Mandatory reporting triggered? If yes → follow statute/policy and notify IC/NTL.

Appendix G — After-Action Review Prompts (BHA)

- What behavioral hypotheses were supported/unsupported?
- Which messages/tone shifts moved the subject?
- Which TPIs helped/hurt and why?
- What time-management and pacing choices mattered?
- Training gaps and policy tweaks?
- Any wellness concerns for team members?

Appendix H — Training Plan (Outline)

- 40-hour Basic CNT (including negotiation psychology, suicide/violence risk, psychosis, neurocognitive issues, SUD basics, cultural competence, veteran/military considerations).
- Annual 8-hour refreshers (case studies, evolving law, language labs).
- Joint exercises with CIT/Mobile Crisis/Co-Responder.
- Optional advanced blocks (threat assessment, family engagement, high-acuity presentations).

Appendix I — Behavioral Health Advisor (BHA) Integration Checklist

Purpose:
To ensure lawful, ethical, and operationally sound use of the Behavioral Health Advisor during crisis negotiation incidents.

Use:
Complete at incident start (or as soon as practicable) and retain with CNT documentation.

A. Role Assignment (MANDATORY)

- □ BHA role designated prior to involvement
  - □ Crisis Negotiator
  - □ Behavioral Health Advisor (BHA)

- □ Single-role rule acknowledged
  - □ BHA will not switch roles during this incident

- □ Role documented
  - □ CNT log
  - □ Incident Action Plan/notes
  - □ After-Action Report (AAR)

- □ Incident Commander is aware and concurs

Red Flag: Any mid-incident role change without documentation and IC approval

B. If Assigned as Crisis Negotiator

- □ Meets CNT negotiator training standard

  - □ 40-hour basic negotiator course
  - □ Team sustainment/in-house training completed

- □ Scope confirmed

  - □ Acting solely as a negotiator
  - □ No diagnosis, assessment, or treatment
  - □ No therapeutic language used

- □ Boundaries acknowledged

- □ No promise or implication of confidentiality
- □ No post-incident clinical care for this subject

□ Insurance awareness confirmed

- □ BHA acknowledges the role is non-clinical

Red Flag: Statements resembling therapy, diagnosis, or counseling

C. If Assigned as Behavioral Health Advisor (BHA)

□ **Consultative role only**

- □ No direct communication with the subject
- □ No primary/secondary negotiator duties

□ **Permitted advisement**

- □ Behavioral indicators
- □ Emotional regulation/stress response
- □ Cognitive distortions
- □ Language framing & pacing
- □ Escalation/de-escalation cues

□ **Chain of communication is clear**

- □ Advice routed through CNT leadership

Red Flag: BHA speaking directly to the subject or coaching in real time without role change documentation

D. Confidentiality & Messaging Safeguards

□ No implication of therapist–patient relationship

□ No assurances of privacy or privilege

□ Subject informed (explicitly or implicitly)
- □ Communication is part of a law-enforcement response

□ All communications recorded/logged per policy

Red Flag: “This is confidential,” “I’m your therapist,” or similar language

E. Documentation Standards

- □ **Notes written in operational language**
  - □ No Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses
  - □ No clinical shorthand
  - □ No treatment plans
- □ **BHA notes integrated into CNT records**
  - □ Not maintained as clinical records
- □ **Role clearly labeled in all reports**

Red Flag: Documentation that resembles “clinical notes” tied to the incident is discoverable and may indicate blurred lines of role clarity.

F. Command & Oversight

- □ **IC approval obtained for BHA involvement**
- □ **CNT Team Leader supervising role compliance**
- □ **Any deviation documented with a rationale**
- □ **Legal counsel notified post-incident if role questions arose**

G. Post-Incident Review

- □ **Role adherence reviewed during AAR**
- □ **Any boundary issues identified**
  - □ Yes → Corrective action/policy review
  - □ No
- □ **BHA participation evaluated as CNT member**

Appendix J — United States Legal Framework (Informational)

Purpose

This annex summarizes key United States federal and state legal considerations relevant to the integration of Behavioral Health Advisors (BHAs) into Crisis Negotiation Team (CNT) operations. It is provided for informational purposes only and does not replace agency legal counsel, state law, or local policy.

J.1 No Treatment Relationship

During CNT operations, the BHA functions solely as an operational advisor. No clinician–patient, therapist–client, or provider–patient relationship is created between the BHA and the subject, third-party intermediaries, family members, negotiators, or responders.

Behavioral observations and recommendations are operational in nature and do not constitute clinical assessment, diagnosis, or treatment.

J.2 Health Information Privacy (HIPAA)

Under the Health Insurance Portability and Accountability Act (HIPAA), restrictions apply to what healthcare providers may disclose to law enforcement — not to what law enforcement may share internally.

HIPAA permits disclosures without patient authorization when:

- A serious and imminent threat to health or safety exists; and
- Disclosure is necessary to prevent or lessen that threat; or
- Information is required for specific law enforcement purposes.

BHAs may advise the command on lawful disclosure boundaries but should not independently request or receive protected health information unless legally permitted.

J.3 Substance Use Disorder Records (42 CFR Part 2)

Federal regulations governing Substance Use Disorder (SUD) treatment records are more restrictive than HIPAA.

Records from federally assisted SUD treatment programs generally may not be disclosed, even during emergencies, without:

- Explicit written consent that meets Part 2 requirements, or
- A qualifying court order.

Prior to requesting or using such information operationally, agencies should consult legal counsel.

J.4 Duty to Warn/Duty to Protect (State Law)

U.S. states impose varying legal duties regarding threats of violence toward identifiable persons or the public.

If a BHA becomes aware of a credible, specific threat during CNT operations, the BHA must promptly notify CNT leadership so that appropriate protective actions may be taken in accordance with applicable state law and departmental policy.

J.5 Documentation & Discoverability

Operational Behavioral Notes (OBNs):

- Are not clinical records.
- May be subject to discovery in legal proceedings.
- Should be limited to decision-relevant observations.
- Must avoid diagnostic labels or treatment recommendations.

Release or production of OBNs is subject to legal review by the agency.

J.6 Liability, Immunity, and Indemnification

BHAs operate in an advisory capacity only and do not direct tactical decisions.

Final authority rests with the Incident Commander and the CNT chain of command.

Agencies should clearly define, through policy and memorandum of understanding (MOU):

- Indemnification provisions.
- Scope of malpractice coverage.
- Applicability of qualified immunity or Good Samaritan protections.

J.7 Subpoenas and Testimony

If a BHA receives a subpoena, deposition notice, or request for testimony related to CNT operations, they must notify:

- The CNT Commander.
- Department legal counsel.
- Their employer or agency counsel, if applicable.

Testimony is generally limited to operational observations and advisory input, not clinical opinions.

J.8 Legal Consultation

Agencies should consult legal counsel when:

- Disclosure questions arise involving protected information.
- Role boundaries are challenged.
- Post-incident review identifies potential liability.
- Multi-jurisdictional operations create conflicting legal obligations.

End of Policy