

## **TAG IT AND BAG IT – US SOCIAL POLICY TOWARD NATIVE AMERICANS**

Original scientific paper

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### **Abstract**

Social policy programs aimed at solving the problems of Native Americans have always been a low priority for the United States Government. Most implemented projects have been incomplete. This article gives a detailed analysis of the legal provisions and system solutions that United States Government has utilized, led by interests independent of the reality and problems in Native American communities. United States social policy is primarily focused on education and health-care issues, but that has been less true for Native American communities - especially in the context of health care, which has long been the responsibility of the United States Congress pursuant to its treaty obligations.

### **Key words**

Social justice, social identity, education, poverty, health care, Native American, minority rights

### **Introduction**

The care of American Indians and Alaska Natives has long been the responsibility of the United States Congress as part of its treaty obligations. This responsibility applies to the 562 federally recognized tribal groups, collectively known as Indian Country, as well as to enrolled tribal members living off of a reservation, many of whom reside in urban Indian ghettos. The exclusive authority of the United States Congress to regulate Indian Country was formally established on October 1, 1783 on the advice of then-President George Washington. (French, 2007) Congress holds the exclusive authority to ratify treaties, including those made with native tribes. Congress also established the basis for federal Indian law with the establishment of the Trade and Intercourse Acts passed between 1790 and 1834 (1802). A major component of these acts was the prohibition of alcohol in Indian Country, a law that remained on the books from its enactment in 1834 until 1953. While seen as protective paternalism by the federal government, prohibition allowed for illicit bootleggers and the creation of drunk towns on the outskirts of all the major Indian reservations. (French, 2000)

Given these circumstances, the indigenous peoples residing within the United States have one of the worst health-care records within society. The United States Government and corrupt Indian agents have long cheated on tribal obligations while Congress abdicated its treaty obligations when it attempted to pass on its responsibilities to local, often unfriendly, governments under the guise of assimilation with the General Allotment Act (1887) and its subsequent revisions (Dawes Act, 1887; Curtis Act, 1898; Burke Act, 1906 and Lacey Act, 1907). These acts were created in order to take away Indian territory, notably Oklahoma, and open it up to white settlers. In 1921, the Snyder Act (1921) addressed the magnitude of health needs, both physical and mental, in Indian Country. Attempts were made in the 1950s again to eliminate Indian Country and federal treaty obligations, this time under the Termination and Relocation Acts (House Concurrent Resolution 108 (1953), Public Law 280 (1953) and the Relocation of Indians in Urban Areas Act (1954)). These actions by Congress did two things regarding Indian health care. First, they led to the transfer of Indian Health Services (“IHS”) from the Bureau of Indian Affairs of the Department of the Interior (“BIA”) to the Surgeon General’s Office and the Public Health Service. Second, they forced the relocation of tribal members to urban settings (usually urban Indian ghettos) creating a new group of American Indians and Alaska Natives who were without the services, albeit often inadequate and poor, of Indian Country.

The reaction to these failed programs led to passage of the Indian Health Care Improvement Act (Public Law 94-437) in 1976 – 37 years following the dire warnings of the Merriam Report (Snyder Act, 1921). At this time, the unintended consequence of chronic alcohol abuse in Indian Country led to the recognition of a newly identified crisis – that surrounding Fetal Alcohol Syndrome (“FAS”) – a diagnosis first recognized in 1973. American Indians and Alaska Natives have the highest incident of FAS in the United States. This disorder has both life-long physical and psychiatric features, including Post-Traumatic Stress Disorder (May et al., 1983).

Clearly, it is not easy to differentiate between physical and mental health issues in Indian Country due to their co-morbid relationship. And, despite the Government’s best efforts to curtail the sale and use of alcohol in Indian Country, alcohol abuse remains one of the major etiologies for both physical and mental health problems among American Indians and Alaska Natives. Substance abuse also is a major cause of family violence, especially that involving women and children victims (Rosett and Weiner, 1983; Weiner, 1983), something that the United States Government is prioritizing in its 21st century “Healthy Nations” initiatives in Indian Country. Consequently, American Indians and Alaska Natives are afflicted with a host of health problems that are disproportionately higher than in the general population of the United States. These problems do not stand alone and are often co-morbid with each other and with corresponding mental health diagnoses, notably depression. A 2010 report of the Office of Minority Health & Health Disparities (“OMHD”) of the CDC (Centers for Disease Control and Prevention, U.S. Department of Health and

Human Services) lists the 10 leading causes of death among American Indian/Alaska Native populations as:

1. Heart disease
2. Cancer
3. Unintentional Injuries
4. Diabetes
5. Chronic liver disease and cirrhosis
6. Stroke
7. Chronic lower respiratory disease
8. Suicide
9. Nephritis, Nephrotic syndrome, and Nephrosis
10. Influenza and pneumonia. (OMHD, 2010)

Co-morbidity between substance abuse, depression and suicidal ideations is a common phenomenon among American Indians and Alaska Natives, regardless of whether an individual resides on or off of reservations. The CDC reported that, during the 1999 – 2004 period, the suicide rate for American Indians/Alaska Natives was 10.84 per 100,000, higher than the overall U.S. rate of 10.75 of adults aged 25-29 (who have the highest rate of suicide generally) and ranked as the second leading cause of death for those aged 10 to 34. Indeed, during this period (1999 – 2004), American Indian/Alaska Native males in the 15-to-24 age group had the highest suicide rate, 27.99 per 100,000, compared to their white (17.54), black (12.80) and Asian/Pacific Islander (8.9) male counterparts of the same age cohort. The CDC report also noted that, among American Indian/Alaska Native youth attending BIA schools in 2001, sixteen percent had attempted suicide within the past year. Hence, compared with other racial and ethnic groups, American Indian/Alaska Native youth suffer more serious mental health problems related to suicide, including anxiety, substance abuse and depression (Gone, 2004; Olson and Wahab, 2006; Frederick, 1973; Berlin, 1987; Tarter and Alterman, 1984; Thaxter et al., 1984 and Yung, 1988).

### **The evolution of Indian health status and IHS in Indian Country**

Indian health, both mental and physical, has always been a serious concern in Indian Country. As a group, Native Americans continue to have high morbidity rates for diseases and deaths. These problems were addressed during the early years of Indian self-determination with the 1976 Final Report of Task Force Six – Indian Health of the American Indian Policy Review Commission and the ensuing passage of Public Law 94-437 – the Indian Health Care Improvement Act.

Final Report on Task Force Six:  
The History of Federal Involvement in Health Care to Indians (Chapter 4)

It is believed that the Indian race was remarkably disease free before European settlers came to the new world. But with the foreign invasion, Indian health began to deteriorate. The natives had no immunity to the disease germs carried by Europeans. Their health was further impaired when they were forcibly removed from their traditional habitat and denied the practice of their customs, one of which was the use of the medicine man and his herbs for healing.

The federal government made sporadic attempts over the years to attend to the poor health of Indians, but the cumulative effects of confining, unsanitary reservation life, combined with government rations, put the population into a cycle of deteriorating health and increasing susceptibility to still further illness. Nothing short of a comprehensive, coordinated health program could have corrected the situation at any given time.

But such a program was never designed. The health care which Indians actually received in the first 100 years was delivered in a piecemeal, inconsistent fashion, and the few appropriations made were never large enough to meet the overwhelming need. There was always an on-going shortage of hospitals, clinics, nursing homes, convalescent centers, equipment, doctors, nurses, dentists, technicians, administrative and maintenance personnel, and staff housing. Preventive or general health care was not possible under these circumstances. Generally, health service was solely of the crisis type....

Health Status of American Indians (Chapter 6)

As mentioned elsewhere in this report, observers remarked that at the time of initial contact with Indians they enjoyed a remarkably good state of health. A study of the status of Indian health in 1955, however, noted that the health of Indians was appalling, citing in decreasing order the following conditions as the most urgent: Tuberculosis, pneumonia and other respiratory diseases, diarrhea and other enteric diseases, accidents, eye and ear diseases and defects, dental disease and mental illness. It is prophetic perhaps that these same conditions, even though the rank may be altered, still remain the most urgent....

Problems of Health Care of Urban Indians (Chapter 22)

About one-half of all Indians now reside in urban areas. The Indian Health Service (IHS) acknowledges that the law and the intent of Congress do not exclude urban Indians from receiving the same health care that the Indian Health Service provides to reservation-based Indians. IHS, however, denies direct services to urban Indians, and justifies its denial of these health services on the fact that it receives a woefully low budget, too low, in fact, to meet the needs of even the recognized tribes in their own communities. IHS considers itself to be "an agency of last resort" for Indians in urban areas. It often requires urban Indians to utilize Medicaid or Medicare (if they are eligible for them) before IHS benefits are provided. The programs of IHS are then used to deal with the problems not taken care of by the Medicaid and/or Medicare systems. The provision of health service to urban Indians who can travel to their "home" IHS facility is not pertinent to most urban Indians who may be hundreds of miles from the facility....

In 1952, the Bureau of Indian Affairs (BIA), under a policy of termination of federal supervision of Indian activities, initiated relocation programs offering both direct job placement and vocational training that stimulated the massive citywards influx of about one-third of the nation's Indian population. However, upon conclusion of BIA support, Indians were left to their own resources and encountered in full force the handicaps that minority cultures have traditionally experienced in our modern competitive society. (Task Force Six, 1976)

Given the obvious failure of the IHS since it replaced the Division of Indian Health in 1955, as reported by Task Force Six, the 94th Congress acted immediately and passed Public Law 94-437 on September 30, 1976. This was known as the Indian Health Care Improvement Act and set the stage for the development of health facilities and services throughout Indian Country and in urban Indian centers.

Indian Health Care Improvement Act (1976)

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act".

Findings

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Section 2. The Congress finds that-

- (a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
- (b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
- (c) Federal health services to Indians have resulted in a reduction in the prevalence and incident of preventable illnesses among, and unnecessary and premature deaths of, Indians.
- (d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. For example, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate approximately 20 per centum greater.
- (e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.
- (f) Further improvement in Indian health is imperiled by –
  - (1) Inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;
  - (2) Shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;
  - (3) Insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies....
  - (4) Related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

(5) Lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions; and

(6) Lack of safe water and sanitary waste disposal services....

Section 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

#### Title V – Health Services for Urban Indians

##### Purpose

Section 501. The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population.

##### Contracts with Urban Indian Organizations

Section 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504.

##### Contract Eligibility

Section 503 (a). The Secretary, acting through the Service, shall place such conditions as he deems necessary to effect the purpose of this title in any contract which he makes with any urban Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake the following activities:

- (1) determine the population of urban Indians which are or could be recipients of health referral or care services;
- (2) identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;
- (3) assist such resources in providing services to such urban Indians;
- (4) assist such urban Indians in becoming familiar with and utilizing such resources;
- (5) provide basic health education to such urban Indians;
- (6) establish and implement manpower training programs to accomplish the referral and education tasks set forth in . . . this subdivision;
- (7) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;
- (8) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and
- (9) when necessary, provide or contract for health care services to urban Indians.... (Snake, 1976)

While these initiatives were certainly needed, they did not totally ameliorate Indian health problems. Duane Champagne (2001) noted that the health needs of American Indians remain critical in both Indian Country and in urban Indian communities. He stated that American Indians are among the poorest, least educated and most neglected of minority groups in the United States. American Indians continue to have the highest mortality rates in the United States for tuberculosis, alcoholism, diabetes mellitus, accidents, homicide, pneumonia and influenza,

and suicide. Heart disease continues to be the leading cause of death, followed by accidents and cancer (the major cause of death among Alaska Natives), with colon cancer and diabetes mellitus, especially Type II diabetes, being high and liver disease and cirrhosis being four times higher than in the general population. Moreover, accidents are the leading cause of death among Indian youth.

An October 2006 National Institutes of Health report on the National Epidemiologic Survey on Alcohol and Related Conditions (“NESARC”) involved the largest and most comprehensive study to date, including the best minority representation in any study of its kind. The findings show that American Indians are still susceptible to mental health issues.

Because NESARC included oversampling of minorities, it is now possible to examine the prevalence of comorbidity in subgroups that never before had been studied. For example, very few large national surveys have been able to examine the prevalence of psychiatric disorders among Asians and Native Americans in the United States. With NESARC, researchers have been able to study race/ethnic differences in the prevalence and co-occurrence of a variety of substance use and psychiatric disorders among Whites, Blacks, Asians, Native Americans, and Hispanics. Researchers reported that 12-month rates of mood, anxiety, and substance use disorders generally were greatest among Native Americans and lowest among Asians. On the other hand, alcohol dependence was associated most strongly with anxiety disorders among Whites, Blacks, and Asians but not among Native Americans.

Another area of concern regarding mental health in Indian Country is that of child abuse – a topic finally addressed in the 1980s, leading to the New Federalism (1989) era of government responses to the unmet needs of American Indians and Alaska Natives. This initiative began as an early initiative of the self-determination years and passage of the Indian Child Welfare Act (1978) (“ICWA”). ICWA was primarily a reaction to programs that sanctioned white adoptions of Indian children, a process that many tribal members saw as a form of cultural genocide. ICWA addressed concerns within Indian Country over the authorities’ allowing of these adoptions and placements without the approval of tribal authorities. ICWA gave the tribes standing to pursue placements of Indian children with Indian families or with tribal-run foster-care facilities: “An Indian tribe shall have jurisdiction exclusive as to any State over any child custody proceeding involving an Indian child who resides or is domiciled within the reservation of such tribe, except where such jurisdiction is otherwise vested in the State by existing Federal law” (P.L. 280). The Department of the Interior was also authorized to provide grants to Indian tribes for the establishment and operation of Indian child and family service programs on or near the reservation.

Absent from ICWA were federal protections against Indian child abuse, including compulsory reporting laws like those that had been imposed on all state jurisdictions by that time. These changes would only come following the 1989 report of the Special Committee on Investigations of the 101st Congress, entitled A

New Federalism for American Indians (1989). Excerpts from the Committee's Executive Summary articulate the nature and extent of these abuses of Indian children.

**Executive Summary: A New Federalism for American Indians**

The Committee found that the BIA also permitted a pattern of child abuse by its teachers to fester throughout BIA schools nationwide. For almost 15 years, while child abuse reporting standards were being adopted by all 50 states, the Bureau failed to issue any reporting guidelines for its own teachers. Incredibly, the BIA did not even require even a minimum background check into potential school employees. As a result, the BIA employed teachers who actually admitted past child molestation, including at least one Arizona teacher who explicitly listed a prior criminal offense for child abuse on his employment form.

At a Cherokee Reservation elementary school in North Carolina, the BIA employed Paul Price, another confessed child molester – even after his previous principal, who had fired him for molesting seventh grade boys, warned BIA officials that Prince was an admitted pedophile. Shocked to learn several years later from teachers at the Cherokee school that Price continued to teach despite the warning, Prince's former principal told several Cherokee teachers of Price's pedophilia and notified the highest BIA official at Cherokee. Instead of dismissing Price or conducting an inquiry, BIA administrators lectured an assembly of Cherokee teachers on the unforeseen consequences of slander.

The Committee found that during his 14 years at Cherokee, Prince molested at least 25 students while the BIA continued to ignore repeated allegations – including an eyewitness account by a teacher's aide. Even after Price was finally caught and the negligence of BIA supervisors came to light, not a single official was ever disciplined for tolerating the abuse of countless students for 14 years. Indeed, the negligent Cherokee principal who received the eyewitness report was actually promoted to the BIA Central Office in Washington – the same office which, despite the Price case, failed for years to institute background checks for potential teachers or reporting requirements for instances of suspected abuse. Another BIA Cherokee school official was promoted to the Hopi Reservation in Arizona without any inquiry into his handling of the Price fiasco.

Meanwhile at Hopi, a distraught mother reported to the local BIA principal a possible instance of child sexual abuse by the remedial reading teacher, John Boone. Even though five years earlier the principal had received police records of alleged child sexual abuse by Boone, the principal failed to investigate the mother's report or contact law enforcement authorities. He simply notified his superior, who also took no action. A year later, the same mother eventually reported the teacher to the FBI, which found that he had abused 142 Hopi children, most during the years of BIA's neglect. Again, no discipline or censure of school officials followed: the BIA simply provided the abused children with one counselor who compounded their distress by intimately interviewing them for a book he wished to write on the case.

Sadly, these wrongs were not isolated incidents. While in the past year the Bureau has finally promulgated some internal child abuse reporting guidelines, it has taken the Special Committee's public hearing for the BIA to fully acknowledge its failures.

Both Price and Boone were sentenced to prison in North Carolina for their offenses. In reaction to the Select Committee's findings, Congress passed The Indian Child Abuse Prevention and Treatment Act (1990). This bill established manda-



tory reporting procedures for certain professionals working in Indian Country by amending Title 18 of the U.S. Code, providing criminal penalties for the failure to report cases of child abuse or neglect – subjecting Indian Country to the same rules regulating child protection that had long been established in all State jurisdictions. The major elements of the Indian Child Protection and Family Violence Prevention Act (Title IV of Public Law 101-630 - Miscellaneous Indian Legislation) are:

1. the requirement that reports of the abuse of Indian children be made to the appropriate authorities in an effort to prevent further abuse;
2. the authorization of such actions as are necessary to ensure effective child protection in Indian country;
3. the establishment of an Indian Child Abuse Prevention and Treatment Grant Program to provide funds for the establishment on Indian reservations of treatment programs for victims of child sexual abuse;
4. a provision for the treatment and prevention of incidents of family violence; and
5. the authorization of other actions necessary to ensure effective child protection on Indian reservations.

The Eastern Band of Cherokee Indians passed their own Tribal Resolution to further keep child predators like Price off reservation lands. Tribal Resolution No. 59, passed December 5, 1991, authorized the Tribal Council to issue a banishment order for anyone, including enrolled tribal members, who are convicted of a sexual offense against a minor.

### **The status of the off-reservation Native American and Alaska Native:**

The forcing of American Indians off of reservations during the Eisenhower Administration in the 1950s has led to generations of marginal Indians, those who share the physical characteristics of their tribal cohorts but lack knowledge of their language or customs. Their health concerns are compounded by the inability to access tribal resources. A 2010 Report issued by the Urban Indian Health Commission highlights these concerns.

During the last 30 years, more than 1 million American Indians and Alaska Natives have moved to metropolitan areas. These original inhabitants of the United States have left reservations and other areas, some by choice and some by force. This change in lifestyle has left many in dire circumstances and poor health. ...Today, nearly seven out of every 10 American Indians and Alaska Natives – 2.8 million – live in or near cities, and that number is growing. Some urban Indians are members of the 562 federally recognized tribes and are thus entitled to certain federal health care benefits, with the bulk of these services provided only on reservations, making access difficult for those in cities. Others are members of the 109 tribes that the government “terminated” in the 1950s. Without this federally recognized status, members of these tribes do not qualify for federal Indi-

an health aid provided by the IHS or tribally run hospitals and clinics. Legislation enacted and treaties signed during the last century guaranteed health care for American Indians and Alaska Natives, but for the most part, recent policies have stripped many of them of their rights to health care when they move to cities. Today's urban Indians are mostly the products of failed government policies that facilitated the urbanization of Indians, and the lack of sufficient aid to assure success with this transition has placed them at greater health risk. Competition for scarce resources further limits financial help to address the health problems faced by urban Indians.

Decades ago, tribes exchanged their land and its vast resources for federal promises of a better life and better health, but the government has not delivered on its promise. As a result, the health of urban Indians has suffered, especially compared to other Americans' health. Today, there is no national, uniform policy regarding urban Indian health, and current federal executive policy aims to eliminate funding for urban Indian health within the Indian Health Service. (Urban Indian Health Commission, 2010)

### **Tribal-centric Treatment Initiatives:**

Some federally funded programs incorporate native clinicians as practitioners. One Indian Health Service initiative that began in the late 1980s was the Regional Youth Treatment Centers ("RYTC") program, through which Indian youth between the ages of 12 and 24 could be referred by their tribe for inpatient treatment for mental health issues. For many of these youth, this is an alternative to being processed through the criminal justice system. Initially, ten IHS RYTCs were created: UNITY on the reservation of the Eastern Band of Cherokee Indians in North Carolina; Raven's Way in Sitka, Alaska; Nanitch Sahallie Program in Keizer, Oregon; the Jack Brown Treatment Center in Tahlequah, Oklahoma; the Phoenix/Tucson Regional Treatment Center in Sacaton, Arizona; the FNN/TCC Adolescent Treatment Program in Fairbanks, Alaska; the New Sunrise Regional Treatment Center in San Fidel, New Mexico; the Four Corners Adolescent Treatment Center in Shiprock, New Mexico; the Inland Tribal Consortium Treatment Center in Spokane, Washington; and the California Youth Treatment Center in Sacramento, California. These programs usually last six months. Many of the clients of these programs suffer from the effects of FAS. One major drawback to the initiative is that referrals need to be made by tribal alcohol and drug programs and these youth, both male and female, must be eligible to receive services from IHS – that is, they must be enrolled members of their tribe. This condition excludes many off-reservation American Indian/Alaska Native youth, especially those residing in government-created urban Indian ghettos. (French & Hornbuckle, 1997)

During this same time frame, there was an effort to establish special credentialing agencies for the certification of American Indian/Alaska Native substance abuse counselors. This movement came out of the awareness that non-native counselors often had a difficult time bridging the cultural divide that separated them from

their native clients – even those trained and employed by the IHS and BIA. Native counselors not only understand their own cultures but also Pan-Indianism, the composite cultural orientation of the vast majority of American Indians and Alaska Natives who have not been fully acculturated into their tribal heritages. The Pan-Indian group encompasses most of the off-reservation natives, as well as a growing number of those residing in Indian Country.

The recognition of the need for tribal-centric mental health counseling centers came about in 1977 at the First North American Native American Alcohol Conference held at the University of California, Berkeley. Following the conference, Oklahoma became the first state to have its own Indian alcohol and drug abuse counselors training and certification program in the late 1980s. In 1988, the Indian group with the highest fetal alcohol rate in the United States, and one of the highest in the world, the Sioux tribes of the Aberdeen Area, created its own cultural-specific alcohol and drug abuse counselors training and certification program. The Northern Plains Native American Chemical Dependency Association serves North Dakota, South Dakota, Nebraska and Iowa – the IHS Aberdeen Area (French & LaPlante, 1997).

Since these beginnings, more native counselors have entered the field. Theresa LaFramboise, a member of the Miami tribe and noted Indian psychologist, provided guidelines for clinicians dealing with native clients:

1. Provide a supportive, open atmosphere for discussing spiritual issues.
2. Use the right helping style (remembering that most clinical approaches are Western oriented).
3. Relax standards of goal attainment (remembering that, traditionally, Indians are community, not individually, oriented).
4. Structure therapy with Native American values in mind.
5. Keep the termination process open-ended (remembering that “termination” reflects a “bottom line” Western concept (LaFramboise, 1997).

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### Biography

**Laurence Armand French**, has the B.A., M.A., and Ph.D. in sociology (social disorganization/social psychology) from the University of New Hampshire, a Ph.D. in cultural psychology (educational psychology and measurement) from the University of Nebraska-Lincoln, and a M.A. in school psychology from Western New Mexico University. He pursued postdoctoral studies in "minorities and criminal justice education" at the State University of New York-Albany and completed the post-doctoral prescribing psychology program including the national exam. He is professor emeritus of psychology from Western New Mexico University; life-member and Fellow of the American Psychological Association; Fellow of the Society for the Psychological Study of Social Issues; Diplomate/Fellow of the College of Prescribing Psychologists (charter member); life-member of the American Society of Criminology; life-member of the Veterans of Foreign Wars (VFW Post 2860); life-member of the Third Marine Division Association; served honorably in the US Marine Corps; and is a licensed clinical psychologist (Arizona). He is a Fulbright Scholar (University of Sarajevo, Bosnia-Herzegovina – 2009-2010) and Visiting Endowed Chair of Criminology and Criminal Justice at St. Thomas University, Fredericton, New Brunswick, Canada.

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