Materials and Collections

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REVIEW OF THE RECENT literature on materials and collections for institution libraries reinforces the conviction that what is involved is special case application of general principles. At the end of his discussion of evaluation of collections, Bonn says:

> Among the concepts and ideas that have appeared and reappeared in this review of the literature on evaluation of library collections, four seem to have the most far-reaching implications for the development and the evaluation of all types of libraries:
>
> 1. The emphasis of library goals and objectives as the foundation for a library's selection or acquisition policy, and as the framework within which the library's collection is to be evaluated.
> 2. The stress on quality and on user needs rather than on quantity and on basic lists alone as the decisive factors in building a collection and in evaluating it.
> 3. The realization that no library can ever be completely self-sufficient, and that increased interlibrary cooperation may be the only possible solution to the growing problem of providing library collections adequate to meet the needs of library users, wherever they may be.
> 4. The virtual necessity of having competent professional librarians in such strategic spots as selection and public service, to insure proper development and use of the library's collection.[1]

Prominent in the literature of collection development for institution libraries are articles and manuals written by consultants from either

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regional medical libraries or state library agencies, or by outreach department librarians in large public library systems. References will be given to the individual manuals as they are mentioned in relation to the type of institution which is their major concern. The general comment prevalent in the literature stresses the importance of articulating the library's goals and objectives relative to the goals and objectives of the particular institution. For example, there is mention of specific core lists as starting points for selection, tailored to the individual institution's needs and not as "opening day necessities" or collection evaluation standards. Detailed instructions are also available for use of existing networks, for consortia establishment or for negotiating contract arrangements; great emphasis is put on continuing education of the person selecting and mediating the collection. A study of hospital libraries by the American Hospital Association, reported in 1971,[2] indicated that less than one-half of all U.S. hospitals provided library service even part-time, and that 45 percent of the personnel in the hospitals with libraries had a high school diploma as their highest educational degree. Nevertheless, the network organizations and their instructional literature keep these principles in simple translation and in scholarly reiteration, before the hospital library and administrative personnel.

SPECIAL PROBLEMS IN INSTITUTIONS OF ALL TYPES

Special problems are related to shifting economic and decision-making power and value definition in the health care delivery system as a whole, causing and being affected by such shifts in the society surrounding the health care system. It is no accident or intellectual fad that systems theory is prominent in nursing, allied health, hospital, medical and health care delivery literature as basic to understanding the process in each. Process in each is in open-system relation to process in the others, and in the surrounding society. The effect of all this on libraries in institutions and on the library world is perhaps as apparent right now in yeasty ambivalence at professional meetings as in the literature. This writer found some dissonance between the literature reviewed for this paper and face-to-face contacts at the annual meetings of the Medical Library Association (MLA) in Seattle and the American Library Association (ALA) in Detroit in June 1977. Publication of some of the convention papers will occur between this writing and its publication; and other papers will address themselves more fully to these issues. This paper intends only to allude to impressions of changes which materially affect "goals and objectives as the foundation for a library's selection or acquisition policy."

There is shifting related to understanding the lay user as patient or as consumer of health care and health information. Early literature has a strong flavor of the assumption that he/she is a patient who needs literature for relaxation, for escape from pain and institutional confinement, and to turn convalescence into a period of self-improvement (sometimes only because of the kind, sensitive librarian's direction). The assumption of dependency on the patient's part was shared by the doctor, the nurse, the hospital or institution, and its librarian. The individual prerogatives and duties of each to deal with that dependency were fairly clear and held in rather firm consensus. Current literature may still define the individual as patient, but the needs and objectives are described in terms of informed consent, formal health education (sometimes even with pre- and post-tests) and patient compliance. Results may be measured by effect on malpractice suits and on recidivism. There is less consensus, but much strong feeling, about whose role is what. Health systems agency literature is also defining the consumer of health information differently than the earlier definition as student in a personal hygiene or social problems course or curious citizen; he is now the taxpaying 51 percent on the planning board. Perhaps the most crucial and shifting change is the individual's own definition of himself/herself as dependent patient, autonomous human being coping with a problem with expert technical assistance, consumer of health care, and taxpaying supporter of the delivery system. (For an interesting story illustrating the second of these three concepts, see Norman Cousins's account of his illness and his doctor-patient relationship.[3]) The librarian, whether of the staff or patient library, has to write selection policies which not only take into consideration the individual characteristics of the institution which can be determined objectively, such as its type, size, specialties, etc., but also its current stance and its trend on these more subjective issues — and must peruse the literature not only for those items which fit the selection policy, but for those trends which may change it, due to both clinical discoveries and social changes.

Grant funding is another area which needs careful consideration. Covering details of this process is beyond the scope of this paper, but discussion with institution librarians indicate that conscious selection/service choices are made in relation to putting energy into securing grants for collection development and materials production, as opposed to putting energy into mediating the collection obtainable from regularly budgeted funds. The policy about grants can be analyzed in relation to the four concepts mentioned above and kept consistent with overall approach to needs and objectives. The presence of grant possibilities through third-

party payments, health care legislation, health information legislation, education legislation, library legislation, and private sources complicates the milieu in the institution library, however.

Selection policy also includes a policy on gifts. The various manuals all include the standard cautions to avoid accepting materials that do not fit the scope of the library, to avoid restrictions on disposal when weeding policy would call for this, and to avoid giving appraisals. Crawford[4] gives criteria for decisions about what might and might not have long-term or actual high monetary value, what should be retained locally, what should be retained regionally, and what should be resolutely destroyed. *The Librarian and the Patient*[5] has suggestions for use of gifts in a variety of ways other than placing them in the collection. Institution libraries will also find the exchange programs such as those of the MLA or the United States Book Exchange useful. The manuals all give details about these and, in addition, the regional medical library manuals describe regional exchange plans. Consortia agreements frequently have exchanges included.

Selection policy will also be influenced by the institution's relation to the community — the extent to which it sees itself as an outreach unit for health education, or is a special subject resource in its geographic area, or has a highly specialized research component.

In the manuals, the library committee is consistently referred to as advisory only, but is considered useful in this capacity. Such a committee would seem especially important in a time of change as a discussion forum to mediate unevenness in rate of change as each group receives different messages from its own professional organization. To achieve consensus on policy, and budget support to implement policy, such a group may be more crucial in an atmosphere of yeasty change in the surrounding ambience than in a time of more stability. The Northwest Institute of Ethics and Life Sciences (6241 31st N.E., Seattle, Washington 98115) is an example of the kind of organization springing up to provide patient advocacy. While many librarians of patient libraries see themselves as patient advocates, and most see themselves as carefully and sensitively responding to needs, in the eyes of the various health care providers the librarian may be seen as promoting his/her own "reading is good" and "more circulation is better" biases. It may, then, be wiser for the librarian to have information on these groups available and to welcome rather than be threatened by such an additional position in his/her institution — even to the point of seriously promoting representation of such a role on the library committee if it exists in the institution. This should strengthen rather than weaken advocacy effectiveness.

APPLICATIONS TO SPECIFIC TYPES OF INSTITUTIONS

HOSPITALS ("ACUTE CARE")

Hospitals will find helpful, and perhaps sufficient, the materials and consultation supplied by the regional medical libraries and the MLA. The *Handbook of Medical Library Practice*[6] is in its third edition, and revision as necessary is considered an important responsibility by the Medical Library Association. The fourth chapter particularly applies to the subject of this paper, but the entire volume is a useful, professional-level reference for any library serving the health science professions. To the benefit of the hospital librarian, the regional medical libraries have produced translations of the handbook principles into language and scope readily usable by the high school graduate, and suited to the small size of many of these libraries. Help from the ground up is given in a context that encourages skill development.[7] At intermediate levels of difficulty between these manuals and the handbook are texts designed for courses at the regional or local level.[8] Consultant service, meshed with the excellent continuing education program of MLA, allows the individual assigned to the collection custody another opportunity to give good service — and to grow as the library grows.

Continuing education courses are given by MLA at its annual meeting and in various regions throughout the year. The various "Literature of . . ." courses are all guides to selection. Further information on these is available from the association and is published with the annual meeting announcements in *Medical Library News*.

Each of the manuals and texts has short lists of essential reference tools with information on their use and purpose. Reference tools are no longer listed in the handbook, because comprehensive listing has required its own separate volume.[9] There are also several core lists, such as the one with frequent updates by Brandon.[10] Selection and use of journals and indexes are also covered in the above. Audiovisual materials are of use in both in-service education and patient education, as well as for patient recreation and for patients with handicaps. Uses for educational purposes are mentioned in the above manuals, and the regional medical library consultants are available for more detailed help with selection. Other purposes will be discussed later in the paper.

The biomedical library network, with the National Library of Medicine (NLM) as its hub, provides a number of resource services for hospital libraries which have a bearing on local selection. Consultants have been mentioned. Consortia are encouraged and subsidized. There is literature

from the now-experienced trailblazers in this level of network-building,[11] and includes an abundance of journal articles and local handouts available at conventions and from regional consultants. There is now also an MLA continuing education course on this subject. The various computer data bases, both the full array from NLM and the various commercial ones in the sciences, are available as relevant from resource libraries within consortia or from the regional libraries.

The guide for the patient's library comparable to the handbook for the staff library is *The Librarian and the Patient.*[12] While public library systems are not as well designed as the biomedical library network, which has assigned regional responsibility, they do have various kinds of cooperative and contractual arrangements for providing library service to hospitals in their service areas. This book covers the similarities and differences in selection for those members of a community who are hospitalized compared to selection within the public library as a whole, discusses ways of drawing on community resources, and describes several different existing patterns of service with details of policy and agreements. While it discusses health education in several places, the book's orientation is more that of good patient libraries to serve the purposes of good public and school libraries when the patient cannot physically avail himself of these.

Before attending the MLA convention in 1977, this writer was aware of a growing interest in patient education, but was really not aware of the acute nature of this interest in library circles as compared to the interest among health care providers, and felt the latter's interest was beyond the scope of this article. Neither time nor the scope of this paper permits attention to the latter's interest here. The literature should continue to burgeon in library publications as well as in those of the health care providers for several reasons: (1) the merger of the Association of State Library Agencies and the Health and Rehabilitative Library Services Division in ALA; (2) a stronger structure for interest groups in MLA; (3) the shift in power brought about by the health system agency legislation; and (4) the widespread effect of AHA's *A Patient's Bill of Rights,*[13] given funding of P.L. 94-317.[14] There may be some delay in completing the reorganization process in these two library groups, but there are committees in both organizations concerned with guidelines, standards, clearinghouse information on programs, and publication. Need for liaison between the two groups is being recognized. Hospital librarians of both staff and patient libraries should find opportunity to contribute in both the Hospital Library Interest Group of MLA (or its successor) and in ASLA/HRLSD, and to benefit from guidelines, selection information and

program ideas from each. *Standards for Library Services in Health Care Institutions*[15] does not address itself to this as fully as is rapidly becoming necessary, and MLA has not yet taken any official position, although the need to take a position is being discussed,[16] and several program meetings have been held on the subject.[17]

One other factor that may change selection in hospital libraries (and other institution libraries) is the copyright law. On June 14, 1977, at the annual meeting of MLA, opinions were expressed that hospital libraries would be materially affected by the new law, but in the absence of statistics, definitions of key terms and information on the Association of American Publishers copy payment center, no one could say exactly what the effects will be. As this issue is published, the effects will be appearing in real time rather than conjecture.

Integration of patient and staff libraries is not as well accepted as is integration of collection and services to all staff in one health sciences library. However, there is agreement that, administratively, there can be integration of all library service under one head librarian even if reasons exist for physical separation of the staff and patient collections with differing policies for service.[18] This writer would like to make the personal plea that nursing and allied health literature be examined closely for content suitable for use in both libraries, rather than delegating it only to the staff library because of its label. Much of it is very suitable in terms of patient education — more so than medical literature — because its focus is on evaluation of the patients' strengths and cooperation with the physician rather than substituting for the physician.

The editor of this issue requested treatment of the topics with less emphasis on hospital libraries than on other institutions. They will, however, be given more prominence here in order to treat the biomedical library network at its point of greatest impact, to be able to refer to it without repeating details as they apply in differing combinations with other services to each of the other types of institutions, and to emphasize the differing mix of network or resource backup applicable.

NURSING, AMBULATORY CARE AND LONG-TERM RESIDENTIAL INSTITUTIONS

This second group of institutions have a higher degree of participation in public library outreach services and are less apt to have their own libraries on site. Selection is therefore similar in content to general public library selection, but with greater attention to format for various handicaps — which will be discussed later. *The Librarian and the Patient* and *Libraries in the Therapeutic Society*[19] contain information about specific

modification of overall public library selection policy for collections used in these special services. Staff in these institutions can usually use the public library in their off-duty time and can access the biomedical library network through their affiliated or parent institutions, so that service will be patient-centered and may have explicit policy excluding service to staff. The logistics of service to staff should be reviewed by the librarian giving service to patients, however, because pulling these institutions firmly into the available local networks may require either modification in selection policy by the public library, or cooperative delivery plans between it and the local biomedical libraries. Creative planning in this area is going on in various parts of the country, although has not yet progressed enough to appear in the literature reviewed here. Perhaps P.L. 94-317 funds will provide the missing piece to tie the service fragments available to these institutions into convenient document delivery networks for staff and patient education, in addition to public library and, sometimes, educational library service to residents.

MENTAL HOSPITALS

These institutions may have selection problems which cover the print materials waterfront, even though they may be considered highly specialized and out of the mainstream by those who relegate the whole concept of mental illness to the "boonies" (as society did physically not so long ago). Physical illness among the mentally ill, especially among the aged, means that the librarian may have to pay attention to the above-mentioned biomedical network as much as many acute-care hospital librarians. Training programs and research programs may require selection in areas overlapping academic selection from the junior-college to graduate-student levels. Many mental hospitals have three different libraries: (1) a staff library, covering a wide range of disciplines and levels; (2) a school library (elementary through high school, depending on the ages of those accepted as patients); and (3) a residents' library which usually is, in character if not by actual contractual administration, a small public library branch. Cooperative arrangements among the three and with their counterparts in the surrounding community are essential. The trend toward community mental health centers means that many requests for staff materials will come from outside the grounds, while within the grounds, patients will require proportionately more intensive work.

Legal materials, remedial educational materials, and materials similar to those used with the developmentally disabled require a larger propor-

tion of the budget than would light and soothing fiction or inspirational nonfiction, highly recommended in times past (and still useful in its place). All of the general remarks about selection in earlier sections apply here, but they are combined in a way that requires a day-to-day, high level of professional skill in selection itself and in interlibrary relations. The MLA Mental Health Librarians Interest Group has prepared a "Literature of Mental Health" CE course. Its syllabus, published in 1977, constitutes an extensive bibliography useful as a selection tool, and the annotations in the instructor's manual which are given in the course itself are even more helpful. The National Clearinghouse for Mental Health Information constitutes an important specialized backup for this group of libraries by providing important free publications, in-depth indexing, and specialized reference service. Consultant service and collection backup may frequently be available from the state library agency. Cooperative agreements with academic libraries may be as helpful to the staff library as agreements with the public library are to the patient library. Cooperative arrangements may also be possible with correctional libraries and law libraries for shared legal materials. Far from being able to survive in isolation with an esoteric collection, the mental hospital librarian may really need a part of everyone's action — and may be able to make a unique contribution in more than one place in his/her surrounding area.

INSTITUTIONS FOR THE DEVELOPMENTALLY DISABLED

These institutions also cover a variety of subjects in their staff libraries. Biochemical and genetic research into etiology, medical and nursing care of the physical health of the multiple-handicapped, special education, rehabilitative therapy, and the operational support of the institution itself mean again that selection in the staff library requires a high level of professional skill to ensure that the best of the current and reference materials are on site, and that there is access through surrounding networks to the additional materials needed. Here the librarian will be aware of, and using to some degree, all of the backup resources mentioned earlier but, in addition, will be particularly concerned with the special education resources in the area (and nationally) in more depth than other institutional librarians.

Here also, the move to the community has meant a noticeable increase in the proportion of the severely and profoundly disabled to the total remaining population, and created an increased need for consultation services within the community, directed both toward local professional

staff of various disciplines and toward families. Therefore, as with mental hospitals, declining census is by no means correlated directly and positively with declining library work load; it, in fact, means greater complexity and very likely increased work load.

In this type of library the absence of suitable materials, especially in the form of audiovisuals and coordinated kits for use in community consultation, is mentioned. Central Wisconsin Center for the Developmentally Disabled in Madison is in a position to assist in the solution of this problem, with its coordinated information services department which combines under one administrative head staff and resident library service, audiovisuals (including a production studio), in-service training resources, patient education, community outreach, and grant-writing for the institution. An energetic ongoing procurement of grant funds allows production of materials in response to documented need and retention for future use in a coordinated way by a variety of intra- and extramural groups.[20] This library has a number of lists of useful material, which are available on request. The materials are primarily for use in connection with the community outreach service in Wisconsin.

High interest, low reading-level materials have been associated with these institutions, and knowledge of what is available is still important. Use is, however, increasing more in the community outreach programs, and within the residential institutions is decreasing in favor of even simpler materials. This means more selection in this area by public librarians, and more consultation rather than selection by the institution librarian. A review of this literature is beyond the scope of this paper, but as starting points for anyone interested in investigating further, two names are: Helen Lyman (Director, Library Materials Research Project, University of Wisconsin, Madison, Wis. 53706), and Laubach Literacy, Inc. (Box 131, Syracuse, N.Y. 13210). Mimeographed handouts on currently useful materials are available on request from many of the state institutions.

The Librarian and the Patient includes discussion of the developmentally disabled, and literature regarding selection is present in the journal literature in too much volume to be detailed here. Educational literature, in addition to library literature, is more fruitful than biomedical literature which has more relevance to staff support — except that the literature of occupational therapy has helpful information on the use of realia on an irregular basis. The major difference in selection for patients in these institutions is the preponderant emphasis on realia and audiovisuals; these will be discussed under special formats.

ACQUISITIONS

GENERAL PROCESSES

The problems here are arranged according to institution size rather than institution type. Individual hospital or institution libraries may be required to go through a purchasing department which does not understand the differences between library purchasing and other kinds of institutional purchasing. Even after the purchasing agent has been educated to the nuances and procedures, the arrangement may have ongoing communication problems which may increase with the size of the institution. The smaller the institution and/or its library budget, the less reliable will be the usual acquisitions instructions regarding using agents or going directly to the publisher, and the greater will be the possibility that a relationship with a local retailer may, on balance, be worthwhile.

Consortia have problems of deciding whether cooperative or centralized acquisitions are more suitable considering their ability to absorb or fund the workload of a centralized service. There are also problems of dealing with differing purchase regulations in member institutions and of setting up communication and decision mechanisms that allow for efficiency and a sense of equity among all the participants. Some institutions have options of: (1) joining larger centralized processing services, (2) purchasing commercial processing, or (3) going it alone. Decisions can be based on cost related to effect on service. Cost includes indirect as well as direct costs, and effect on service includes speed of availability of materials related to urgency of user need, as well as amount of staff time taken from mediating the collection or carrying on library-based programs supportive of the institution's goals and important to the library's visibility. In some cases, the institution library has no option but is, by act of outside administration, part of a larger system. In this case, the problems relate to responsiveness of the system to the individual institution's needs, influencing that responsiveness, or being able to make suitable, on-site adaptations.

There is, of course, a great body of general acquisitions literature. There are sections in the handbooks, texts and manuals mentioned earlier that are specifically suited to institutions. MLA offers a continuing education course in this area which considers the range of situations experienced by biomedical libraries. Courses at varying levels, with varying relevance to institution libraries, are offered through other library groups, both nationally and regionally. For individual problems, the aforementioned re-

gional medical library, state library agency and public library system consultants are widely available.

SPECIAL CONSIDERATIONS

Locally produced working documents and publications may have current use, archival value, or regional or professional historical value wider than that being attended to by the producers. The institutional librarian who is visible as an acquisitions clearinghouse for these materials will be able to build ephemera files in-house and facilitate acquisitions of such materials by appropriate depository libraries and archives without becoming an archives curator in the process.

Acquisition of pamphlets is sometimes cautioned against and sometimes suggested as a suitable activity for a volunteer or service organization. If it can be acquired with a minimum of the librarian's time, a pamphlet file does provide a valuable supplementary collection, especially for patient education. Various voluntary associations, and pharmaceutical, appliance and food manufacturers are good sources of such material; listings appear regularly in health care professional journals. Here, of course, the usual library approaches to vertical files are applicable. In one medical school library, a listing of 270 associations and companies was compiled to which requests for information about available free materials were sent.[21] Response varied from none, to sending a requested item with no further comment on the cover letter, to supplying a catalog, to supplying a catalog with information regarding its update schedule, to putting the library on a regular mailing list. A tally of the 270 showed: 67 did not reply or do not provide free or inexpensive materials, 121 provide free materials, 60 provide materials for a price (frequently within the $.10-.50 range), and 22 provide both free and priced materials. The library technician in charge of this project believes that the proportion of free to priced material is decreasing, but she has not kept comparative figures long enough to demonstrate this. Such lists become outdated rapidly except for the very large associations and firms; a followup mailing as soon as six months later results in a substantial number of returns as undeliverable, so it will usually be more profitable to build files from recent directories and advertisements than to use published lists that are even only two or three years old. A service club with an interest in keeping the source file up to date and contributing $50-$100 a year for postage and inexpensively priced materials might take pride in such a project as its own more than it might in contributing the same time and money in a general unidentified way. Most library staffs in institutions would, how-

ever, have to be very selective of only the most productive stable sources in order not to take time from acquisitions of other materials or from services.

The National Library of Medicine annually publishes a guide to its publications and their procurement as a supplement to *National Library of Medicine News*.[22] Acquisitions of government documents as a subject in itself is beyond the scope of this paper, but they are of some importance to institution library collections. The consultants mentioned earlier and the nearest depository library are sources of information, while some institution libraries will find it useful to obtain the *Monthly Catalog of U.S. Government Publications*.[23]

ORGANIZATION

CLASSIFICATION

In some institutions collections are so small that classification is unnecessary or that broad subject area divisions are quite sufficient, whether achieved by using the first level of a classification scheme or by using the term on a color-coded shelf sign with the color indicated on the spine by tape. In larger collections, a classification scheme is necessary. In the biomedical libraries, the NLM schedule seems dominant, because the other schemes (e.g., the Cunningham Classification) are no longer being revised. For collections with large mental health or education components, the Library of Congress Classification (LCC) has advantages — whether it is used exclusively or coordinated with the NLM schedule. Where the clinical medicine portion is small, the use of the LCC "R" schedule may be no problem; where the basic science portion is large, the LCC "Q" schedule may be preferable to the NLM system. The Dewey Decimal Classification (DDC) is used in some institutions — and is probably the system of choice in a resident's collection in a community where DDC is used in the public libraries which will be used by the residents upon their return to the community.

In collections for the developmentally disabled, color codes and symbols may be used for books. Realia, toys and games will be more functionally organized according to the skills which they are designed to develop rather than by name.

CATALOG

The amount of original descriptive cataloging necessary in a given institution will depend on the access to national cataloging sources or to

network processing, as already discussed. Documents produced within the institution usually can receive vertical file treatment, but may require original cataloging.

Subject cataloging consistency throughout the collection, insofar as possible, is to be preferred, i.e. the use of the same subject heading list for other types of materials as is used for books. Depth of analytic subject cataloging is influenced by size of collection and presence of a professional mediator. Where the collection is small, with the mediator usually present who is intimately familiar with it, a shelflist may be sufficient in addition to author/title listings. Where the mediator is present only a fraction of the time, a small collection may be more useful with in-depth analytics, whereas this would be unnecessary in a larger collection. Annotated lists may sometimes substitute for the author/title catalog in a small collection. Book catalogs or computer-produced microfiche catalogs may be the very serviceable choice in institution libraries that are part of a larger system. Rotating card files may be better than drawers in patient's libraries where manual dexterity is not adequate to manipulate cards in the usual cabinets.

PHYSICAL ARRANGEMENT

Whether materials should be arranged by format or with all formats intershelved by subject will depend both on space availability and use patterns. Institution libraries are small enough that distance to audiovisual equipment from any place in the collection need not be great. Thus, both with staff collections and patient education collections, subject integrity may be paramount, especially where stack space and packaging of non-book items allow for this. In many patient library collections, subject content is subordinate to activity. Here separation of various formats will be preferable — including keeping the live-animal portion of the realia in the place most suited to their health and convenient to their care, rather than next to the books about them.

One of the drawbacks to combination of resident and staff libraries is the differing activity which remains even if one group is not being restricted from access to the materials of the other. Staff may want quiet individual study space, or space for small conferences which may require some level of confidentiality. Resident libraries may, on the other hand, be expressly arranged to promote socialization and group activity; for example, a pool table can be an asset in such an arrangement (except for the very rare occasions in which the cues become weapons).

A third factor which must be taken into account in institution librar-

ies more so than in others — although more and more attention is, and should be, given to this in all libraries — is accessible arrangement for the physically handicapped. (The ninth chapter of *The Librarian and the Patient,* "The Library as a Therapeutic Environment," addresses itself to this in great detail, which is therefore unnecessary to repeat here.)

USE OF THE COLLECTION

CIRCULATION

Many staff libraries in institutions allow 24-hour access to the staff library by controlled access to the key. This necessitates an honor system for charge-outs in off-hours, and a system simple enough to be used as self-charge by someone in a hurry to return to the unit.

Policy must cover the use of resident library materials by staff and the use of staff library materials by residents. The reasons that this must be spelled out have been covered in the section on selection. Here it need only be affirmed that no matter how restrictive (for whatever reason) the policy is, materials should be circulated from on-campus sources before resorting to interlibrary loan from outside sources.

Fines for overdues are not applicable in these libraries; however, responsibility for replacement of lost materials, and for securing the return of or sharing of materials when others need them do require policy. In the staff library, peer pressure is generally more effective than librarian pressure. Fostering, in deed as well as word, the idea that the collection represents an important working tool for the institution which requires responsible care is most effective. Confidentiality of reader records within the institution community may have to be relaxed to allow sharing of an item by staff members having simultaneous but not constant need for it. Responsible followup by the librarian should keep staff, whose attention is absorbed elsewhere, from forgetting that they have library materials in their possession, and from depleting the collection of material necessary to answer questions within the library. Materials from other places need to be returned as agreed. Beyond this, there is little justification for regulation. In the resident library, return may be dependent on the librarian's rounds, or may be part of therapeutic habit-building; emotional dependence on a particular item may need to be respected until a personal copy can be secured. Flexibility is the operational approach in circulation policy in institutional libraries, but underlying assumptions bear clear statement so that consensus among librarian, funders and users gives firm purpose the parameters within which flexibility can comfortably be granted.

Replacement of lost materials generally is requested of staff, but policies of library clearance before final paycheck issuance vary widely. Replacement of lost materials generally is not required of patients (signifying their dependent status), and in contract arrangements is frequently not required of the institution responsible for care, either — for the very good reason that an administration only lukewarm to library service to patients might well refuse service from the library agency if it had to assume responsibility for the materials. Practice on this point varies. The appendix of *The Librarian and the Patient* has contracts and agreements which illustrate various approaches to avoiding abuse and figuring some replacement cost as normal operating expense. The point is made that the goodwill generated by service to patients may generate gifts sufficient to offset losses. Returns from discharged patients seem to be facilitated by good relations with the nursing staff and book boxes in the units, more than by business-office library checkoff systems (although these have sometimes been used in long-term institutions where turnover is not too great). In wards where destruction of materials is somewhat the rule, expendable collections of gifts are used, with replenishment the only circulation activity.

SPECIAL METHODS OF CIRCULATION

Book-carts, mail delivery, bookmobile stops at specific institutions, bookmobiles with special lift apparatus for access by the handicapped, deposit collections on closed wards, or rotating collections for infrequently visited facilities are all specialized circulation ways of serving those in institutions without libraries or those who cannot get from bed or ward to the institution library. There is, again, a large body of journal literature with summaries and principles given in the books already cited. The main guiding principles seem to be: (1) personal contact with the user adds values beyond the delivery of the item or its passive presence; (2) where a small collection is catered to an individual or small group of individuals, selection needs to be tailored closely to that individuality; and (3) materials should be brought to the bed patient as a refusable service, not as a burdensome intrusion.

ROLE OF THE LIBRARIAN

This is a personal statement this writer makes from a dual background: that of provider of health care apart from libraries, and librarian apart from the health care scene. There are ethics and legal responsibilities regarding personal freedom, professional responsibility and confidentiality

in each profession. In some ways these are at opposite poles in underlying assumptions. The library profession stands for personal freedom to seek information without labels, and without being labeled, and promotes an ideal of access to all of the human record, governed in the final analysis only by the individual's autonomous seeking and desire to know. The health care professions have stood for an ideal of "do no harm" and of having correct knowledge to apply to an individual who has, at least temporarily, surrendered or been deprived of some autonomy. The individual is in a different relation to each, and one of the strengths of the institution library has always been that it brought something of the outside into the institutional setting. The public library across the street from an institution represents one end of a continuum, with the health educator or bibliotherapist who is a full member of the health care team at the other end. There are different assumptions on the part of the health care team and on the part of the patient about roles relating to safety of revealing information, expectations of boundaries of confidentiality, responsibility for outcome, protection, and control. The institution librarian is somewhere in the middle of this continuum and needs clarity within, and explicit explanation without, so that both the patient and the staff know where he/she stands and how far he/she is willing to go. It is also important that the librarian and the staff understand what will be lost to the patient if he/she goes, or is required to go, all the way to the health care team side without leaving someone in the library to mind the shop as a professional librarian only.

A particular incident in this writer's experience in a mental hospital library brings this problem into focus. A female paranoid patient spent much time sitting in the library staring at staff in such a way that staff members had a somewhat uneasy feeling of being spooked. Her reading tastes were in the occult. One day she made a specific request for a book on witchcraft which was listed as a reference in a parapsychology book she had been reading. As librarian, I felt obligated to send the interlibrary loan request to validate our claim to be operating a good public library service in the institution. As a nurse, I knew that witchcraft is not a particularly apt bibliotherapy prescription for paranoid schizophrenia. Therefore, I felt obligated to clarify the situation to the health care team. I went to the counselor and explained that, should he see the patient with the book, he should be aware that she had it because her request had been respected and not because she had been "reader guided" into choosing it, and that he would be notified if and when the book arrived, if he wished. It was expected that he deal with her use of the book, not with

her right to have her request respected by the library. He agreed that the book should be given to her without his prior censorship, agreed to keep his relating to her around her use of the book, and thanked me for the forewarning. What happened next was not predicted or controlled; it came as a serendipitous gift. This particular system had a good interlibrary forwarding and report-back procedure; thus, at regular intervals, the patient was informed: "Your request arrived at the state library. They didn't have the book, so it has been forwarded to the Bibliographic Center"; "The Bibliographic Center received your request and could not fill it from the region, so it has been forwarded to the Library of Congress"; and "The Library of Congress has forwarded your request to a Canadian university." When the book did indeed arrive from a Canadian university library, the patient had real evidence that her request had put an international library network into motion at the academic level. This writer never discussed the book or its contents with the patient, or discussed the incident with her counselor (except for the initial conference to clarify the librarian role). Some time before the request, the patient had been considered unlikely ever to be a suitable candidate for halfway house plans. A few months after the interlibrary loan incident, she was placed in a halfway house near the public library branch. It is unclear what happened on the ward because of the book, or completely unrelated to the book, to bring about this changed disposition. Nevertheless, in the library, as progress of her request was related to her (showing her the forms each time), her relationship to the staff and her reading interests became more logical and "in contact." What might have happened if the state library had had the book and had sent it immediately cannot be determined, nor can what would have happened if the state library's policy had been to refuse to forward requests for patients. It was fortunate, however, to have distinguished the role of librarian from that of bibliotherapist or health care provider.

A number of institution librarians have clarified their position in their own minds at somewhere midpoint on this continuum, and have found it possible to explain this position to both patients and staff — e.g., to the staff: "Up to this point I will not compromise the user's decisional integrity and confidence even if he is a patient"; and to the patient: "Past this point I have to remember that we are in an institution and will have to share this information with the staff unless you will tell them yourself." A number of other librarians, who have muddied ambivalence about their role, perhaps deny that there is any difference and may jump back and

forth between the two ethics in actual practice. The plea made here is that the staff and patients not be mystified by the librarian jumping back and forth between the role of librarian and that of health care provider through information — and that the librarian who chooses to be the health care team member-with-library-skills be aware that some of the patients may still need access to libraries with unattenuated librarians. Selection, network participation, circulation, and reader guidance practice will all be affected by clarity or confusion on this role issue. Any spot on the continuum that fits both the institutional reality and the librarian's individuality is the right place, as long as all involved have the same information and are not laboring under conflicting assumptions.

SPECIAL FORMATS AND EQUIPMENT

AUDIOVISUAL EDUCATIONAL MATERIALS

Microforms are a bridge between print and nonprint media, in that content is print but method of use requires equipment not so different from that used by other audiovisuals. Furthermore, some equipment provides magnification sufficient for the visually handicapped. Space and price considerations may cause microforms to increase rather than decrease in some institutional libraries.

More usual educational audiovisual materials include films of various sizes, videotapes, slide-tapes, filmstrips, and audiotapes. The revised copyright law may affect some libraries where copying and reformatting was being carried on by their supplying system. However, the general problems will be those of expense, bibliographic control and obtaining adequate evaluation. Again there is a large body of general literature. The handbook has a full chapter with many references,[24] and most institutions will find audiovisual specialists in their backup system, if not closer to home. Union lists of audiovisual holdings is one of the highly attractive projects for consortia, although within an institution, in-service departments may be more possessive of departmental audiovisuals than of their departmental book collection. Production capabilities exist very widely and in-house use of videotape as a teaching-therapy modality is common. Speech compressors/expanders add to the flexibility of audiotapes as learning devices. Whether audiovisuals are part of the library or a separate department varies, but in any case, "kit" arrangement (by actual packaging or by bibliographic listing which combines print and nonprint on the same subject) allows for strengthened learning.

AUDIOVISUAL RECREATIONAL MATERIALS

The same formats with recreational and general content form an important part of the resident library collection, although here phonodiscs will be added, and video- and slide-tapes may not be important. Audios will not be usable by the deaf except where music rhythm comes through as perceptible vibration. Audiovisuals will be more usable by the deaf with captioning, a printed text in hand, or an accompanying sign-language interpreter in group presentations, as lip-reading is only a sometime skill among the deaf, and is frequently poorly or not at all provided for in the presentation. (Teletypewriter phone connections — TTY — may not be as applicable to the institutionalized deaf as to those in their own homes, but can be mentioned as something which may be applicable in some institutions for either staff or residents, and of which the institution librarian, especially the hospital librarian, should be aware in planning for discharge of patients newly deaf.)

Audiovisual materials may have the widest audience in an institution and form strong group activity foundations. Levels of activity and purpose may vary with a given piece, and here the skill of the librarian in guiding and assessing use may be as crucial to full utilization as is reader guidance with print materials. It is also important to consider additional languages in these formats (as in print materials) if different ethnic groups are being served.

MATERIALS AND EQUIPMENT FOR SPECIAL HANDICAPS

Since the deaf, with justification, feel they are more an ethnic group than a handicapped group, they are mentioned above, and thus separated from discussion of the needs of the developmentally disabled, the blind and visually handicapped, and the physically handicapped.

Toys, puppets, pictures, realia and live animals predominate in libraries for the developmentally disabled. Toys may range from trampolines and bicycles to very small objects. They are acquired for use in developing specific skills such as ambulation, balance, gross motor skills, fine motor skills, sensory discrimination, speech and social skills. Sources both of materials and evaluative information include the literature of early education, special education, occupational therapy and physical therapy. An important source is the American Foundation for Educational Teaching Aids (A. Daigger Co., 159 W. Kinzie, Chicago, Ill. 60610), but the library that regards this as an important source will have three file drawers of catalogs, and will search widely for the appropriate materials.[25]

Realia includes a kitchen with color-coded utensils and recipes; a

tactile wall with a fascinating array of switches that light lights or cause movements; levers, catches and fastenings that can be turned, opened and closed — all against a textured cloth background (even heavy carpeting), with other textures, such as small mirrors, distributed throughout. It also includes real-life objects of many kinds, and live creatures such as fish, plants, gerbils and a rabbit. Everything is chosen for more than one level of use, if possible, but also to allow one idea to be repeated many times at whatever level. Picture files and films follow this principle, also.

For the physically handicapped, many of the above are useful aids for exercise and retraining; they may find materials for the blind useful because of problems with manual dexterity in holding materials. In addition, they may need book-holders, page-turners, overhead projectors, prism glasses, or other assistive devices in order to use regular print materials.

Talking books and braille typewriters have been well known for many years. The radio talking book (an FM subchannel broadcasting to specially tuned receivers) is somewhat newer and spreading. The local programming includes reading the newspaper and giving local shopping and entertainment information, as well as reading magazines and reading books serially. Blind users may want to have a particular talking book obtained because of missing part of the radio talking book.

Information about these and other LC Division for the Blind and Physically Handicapped programs and its research endeavors may be obtained from the regional libraries for the blind and physically handicapped. Individual equipment may be borrowed from the regional libraries also, some under the regular program for use as long as needed, and some as a demonstration unit to aid the library or individual to make a decision about purchase. The American Federation for the Blind is a source of information regarding equipment for the blind for many activities of daily living as well as for reading.

Closed-circuit electronic magnifiers, in a price range of $900 to $2000 (with attachments), have been available for some time, as has the Optacon, an "optical to tactile converter" which converts print into a vibrational pattern which the blind can feel. At least one library has reported obtaining this device.[26] It is an expensive device, and for many people provides only slow, letter-by-letter reading. This may be very worthwhile for personal financial statements and correspondence, but is not a substitute for other methods of obtaining book information.

The LC Division for the Blind and Physically Handicapped (DBPH) is engaged in research with: "emphasis on supporting developments and refinements that result in cost-effective multiple-use devices and materials.

... [It] also undertake[s] experimental ventures — testing applications of various technologies to determine whether they can be and should be incorporated into the Division's program."[27] A list of projects provided by the division includes a number of user surveys and projects to refine existing equipment and programs. However, several exciting projects listed were described in detail in the HRLSD program meeting at the ALA conference in Detroit, and deserve mention here.

The Telebook project in its first phase involves transmitting talking books by telephone in the Washington, D.C. area. Phase III will include a field test in Columbus, Ohio, using cable TV transmission and FM receivers. These services would be very convenient in many institutions.

The Kurzweil Computer Products company (Cambridge, Massachusetts) is working with the DBPH to adapt a machine which now converts print into speech to convert print into braille. This machine would be for institutional purchase rather than individual purchase, because the cost would be more than $10,000, but it would allow the blind reader to read any book in a library owning the machine. This machine is not likely to be purchased by many of the libraries covered by this article, but would be of interest if located in the area.

Finally, perhaps the most exciting item is ELINGA, a cassette braille machine which is only about the size of a small book (8″x9″x2″), and which allows exposure of braille characters through a small aperture from a cassette which can then store a 220-page book equal to 6 braille volumes. Braille cassettes could be produced on demand in all libraries having sound duplication equipment, with no storage problem. Frank Cylke, chief of DBPH, informed conference attendees that 500 of these machines are now being tested, and that DBPH hopes eventually to be able to supply one for each braille-reading person in the country.[28]

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