Introduction to the Festschrift

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In 2009, our university hosted a conference to honor Gary R. Bond, Ph.D., as he retired from Indiana University–Purdue University Indianapolis (IUPUI) after 34 years of academic service. This celebration brought together researchers, students, policy makers, administrators, clinicians, family members, and consumers who had been influenced by his work in psychiatric rehabilitation. Bond has been a champion of what people with severe mental illness can achieve, particularly in the employment domain, and his contributions to our field have been vast. Through it all, he has emphasized the role of rigorous research methods to improve quality of care.

One line of his work that has had far-reaching impact across a number of service domains is fidelity of program implementation. Bond pioneered the use of fidelity scales in psychiatric rehabilitation, with early work denoting the need for and uses of fidelity (1). He has remained a staunch advocate for measuring implementation and has provided numerous examples of how to best assess program fidelity, including (in this issue) refining a fidelity scale for supported employment (2).

In this Festschrift, we present a sampling of current work in fidelity, some of which came from the conference—and all of which has been influenced by Bond. Teague and colleagues (3) provide an overview of current issues in fidelity assessment, highlighting the complexity of assessment and the need to balance the often competing goals of effectiveness and efficiency. They describe four examples of fidelity scales.

Fidelity assessment in psychiatric services began at the level of the program but, as Teague points out, should also involve assessment of quality at the level of the clinician. Other Festschrift articles are related to clinician-level instruments. McGuire and colleagues (4) present a clinician-level fidelity tool for illness management and recovery. Preliminary work supports the reliability and validity of the tool. Future work is needed to assess how this aspect of program fidelity is related to fidelity to the larger program and to consumer outcomes. Similarly, I and my colleagues (5) present psychometric analyses for a scale to assess shared decision making in psychiatric care. This scale assesses the quality of the dyadic interaction in terms of how the consumer and provider work together to make decisions about the best course of treatment. Finally, Lu and colleagues (6) also present a fidelity scale at the level of the clinical interaction and demonstrate the utility of fidelity assessment and feedback within the context of a comprehensive training program.

The term fidelity has become an integral part of our language in psychiatric services today, in large part because of Bond's work. Fidelity to evidence-based practices is an important driver of high-quality care leading to improved consumer outcomes. However, as Bond and his colleagues Monroe-DeVita and Morse (7) remind us, program fidelity is one tool. A comprehensive approach, in addition to assessing fidelity, is needed to implement and sustain implementation of evidence-based practices.

For Bond, retirement from IUPUI has meant not the end of a career but relocation (to Dartmouth Medical School). In this issue alone he shows us that his career is still in full gear, with three new articles. We have no doubt that his work will continue to have a large influence in our field for years to come.

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