G. Douglas Bevelacqua

March 1, 2014

The Honorable Terence Richard “Terry” McAuliffe
Governor of Virginia
1111 East Broad Street
Richmond, Virginia 23219

Re: *Letter of Resignation*

Dear Governor McAuliffe,

It has been my honor to serve at the pleasure of the Governor since 2010 when Governor McDonnell appointed me Inspector General for Behavioral Health and Developmental Services.[1] Prior to this appointment, I had advised Bob McDonnell on mental health issues for about fifteen years, and I had been an advocate for people with mental disabilities at the local, state, and national level for twenty-five years. After my former agency was consolidated into the Office of the State Inspector General (OSIG) on July 1, 2012, Governor McDonnell reappointed me Associate Inspector General in the new Office. Immediately prior to this resignation, my position in the OSIG was Director, Behavioral Health and Developmental Services Division.

As you may be aware, the OSIG has extensive statutory mandates that include the investigation of waste, fraud, abuse, and corruption; the operation of the state fraud, waste, and abuse hot line; coordinating and setting standards for internal audit programs of executive branch agencies; and, conducting performance reviews of executive branch agencies to assure appropriated funds are properly spent.

The OSIG’s behavioral health and developmental services mandate was copied verbatim from the former Office of the Inspector General’s (OIG) Code requirements.[2] These responsibilities include conducting annual unannounced inspections at the sixteen facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS); investigating specific complaints of abuse, neglect, or inadequate care at state-operated facilities and other programs operated by private providers; and reporting serious problems and recommending corrective action to the General Assembly and the Joint Commission on Health Care.

During the past twenty months, I have tried, unsuccessfully, to convince the OSIG leadership that the quality improvement responsibilities of the Office for behavioral health and developmental services (BHDS) are different from investigating corruption, operating a waste, fraud, and abuse hotline, or promulgating standards for internal audit programs. Throughout this process, I have been continually

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1 Governor Gilmore established the Office of Inspector General for Behavioral Health and Developmental Services in order to create an independent system of accountability following a U. S. Department of Justice investigation into the deaths of patients at state-operated mental hospitals. As of 2012, the OIG’s *Mission* was “to provide an independent system of accountability to the Governor, the General Assembly, and the citizens of the Commonwealth for the quality of services provided by the Department of Behavioral Health and Developmental Services (DBHDS), and other providers of behavioral health and developmental services, in order to protect the health and welfare of service beneficiaries.”

2 *Code* § 2.2-309.1. Additional powers and duties; behavioral health and developmental services

cautioned by OSIG leadership that the BHDS reports contained elements that were “too emotional,” “imprecise,” “incendiary,” or that these reports needlessly “editorialized.” It is noteworthy that individuals with no background in behavioral health or developmental services, and no first-hand experience with the specific topics, repeatedly changed the content and form of the work produced by the BHDS Division.

Recently, the Report of the Critical Incident on November 18, 2013 in Bath County has been the subject of iterative OSIG revisions that, in my opinion, will diminish the Report’s usefulness as policy makers consider changes to the Commonwealth’s emergency services response system. If I were responsible for publishing this report, it would have been issued weeks ago and it would have contained conclusions that were removed because they were considered speculative or too emotional.

One of those conclusions was that the DBHDS failed to take meaningful action to implement the Recommendations from the OIG’s 2012 Report until after November 18, 2013, and that had the DBHDS taken timely action on these 2012 Recommendations, it most likely would have produced a different outcome on November 18, 2013.[3] This conclusion was deemed too speculative. It was removed by individuals with a limited understanding of the Commonwealth’s public sector behavioral health system who had no involvement in the actual Critical Incident investigation.

If I were responsible for publishing the Critical Incident Report, the timeline for November 18, 2013, would have included Senator Deeds’ contemporaneous statement, already in the public domain and corroborated by multiple sources that, “the system failed that day.” However, that statement was considered too emotional for this Report—even though this family member was the only witness to all of the events on November 18, 2013, and that, by any standard, his observation was accurate.

Last Friday I spoke with Senator Deeds about the legislative initiatives he sponsored in this session of the General Assembly and advised him that, in my opinion, the proposed statutory revisions are consistent with the findings and recommendations in the Critical Incident Report as it was originally drafted.

I regret this resignation more than I can put into words, but I feel that I can no longer be an authentic, independent voice of accountability for the citizens of Virginia on matters of behavioral health and developmental services, and that I must move-on. I will look for other opportunities to serve our disabled neighbors and their families.

Please accept my resignation effective March 1, 2014, and feel free to contact me it you have any questions concerning the comments above or this resignation. I remain

Sincerely,

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3 *Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* dated February 28, 2012. This Report described a ninety-day study and confirmed that substantial numbers of individuals meeting criteria for a TDO admission were not admitted to a hospital and many more individuals received a TDO admission after the six-hour time limit for ECO’s. The DBHDS stated at the time that the OIG’s “incendiary” presentation “materially misrepresented” the behavioral health system. I am certain, that, as an employee of the OSIG, I could not publish OIG Report No. 206-11 today.

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C: Senator Linda T. Puller, Chair, Joint Commission on Health Care
Senator Creigh Deeds
Michael F. A. Morehart, State Inspector General