LOS ANGELES COUNTY

AUDITOR-CONTROLLER

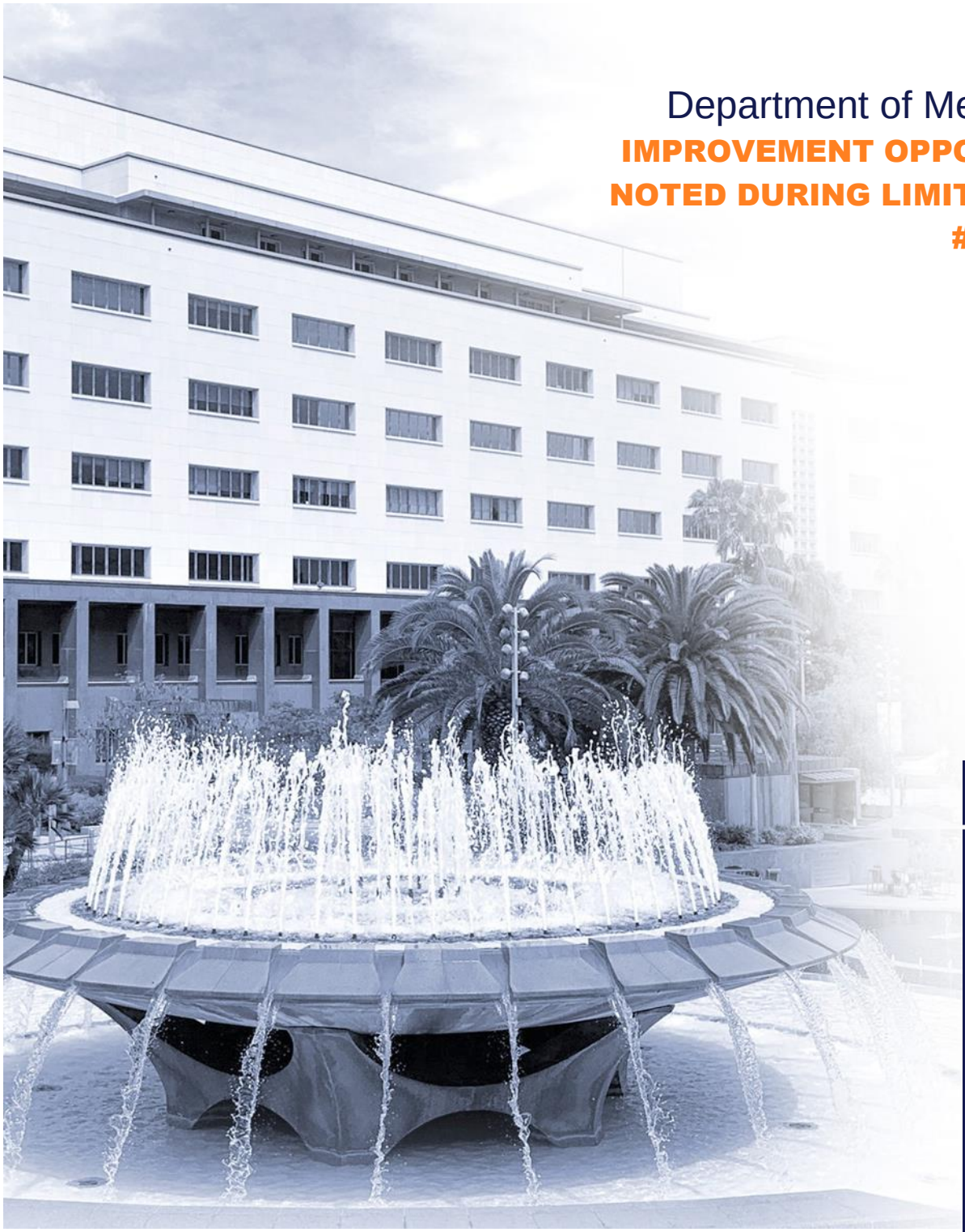
Arlene Barrera
AUDITOR-CONTROLLER

Peter Hughes
ASSISTANT AUDITOR-CONTROLLER

Robert Campbell
DIVISION CHIEF

OFFICE OF COUNTY INVESTIGATIONS

December 19, 2019



Department of Mental Health

IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2019-15110

NUMBER OF RECOMMENDATIONS	
PRIORITY 1	2
CORRECTIVE ACTION REQUIRED WITHIN 90 DAYS	
PRIORITY 2	0
CORRECTIVE ACTION REQUIRED WITHIN 120 DAYS	
PRIORITY 3	0
CORRECTIVE ACTION REQUIRED WITHIN 180 DAYS	

BOARD OF SUPERVISORS

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FIRST DISTRICT

Mark Ridley-Thomas
SECOND DISTRICT

Sheila Kuehl
THIRD DISTRICT

Janice Hahn
FOURTH DISTRICT

Kathryn Barger
FIFTH DISTRICT

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COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-3873
PHONE: (213) 974-8301 FAX: (213) 626-5427

ARLENE BARRERA
AUDITOR-CONTROLLER

ADDRESS ALL CORRESPONDENCE TO:
OFFICE OF COUNTY INVESTIGATIONS
500 W. TEMPLE ST., ROOM 515
LOS ANGELES, CA 90012-3756

December 19, 2019

TO: Jonathan E. Sherin, M.D., Ph.D., Director
Department of Mental Health

FROM: Robert G. Campbell, Chief
Office of County Investigations

SUBJECT: **IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2019-15110**

During a limited review at Department of Mental Health (DMH), we noted areas where DMH can strengthen its internal controls over the Office of the Public Guardian (PG) mailroom to safeguard incoming mail. Please see Attachment I, Table of Findings and Recommendations for Corrective Action, for details of our observations and recommendations. The Auditor-Controller's follow-up process and internal control disclosures are included in Attachment II.

Review of Report

We discussed our report with DMH management. The Department's response (Attachment III) indicates **general agreement** with our findings and recommendations. We concur with DMH's assessment that an extended 120-day timeframe is appropriate to implement corrective action for Issue 2 concerning mailroom security.

We thank DMH management and staff for their cooperation and assistance during our review. If you have any questions please call me at (213) 893-0058, or your staff may contact Chief Investigator Greg Hellmold at (213) 892-0243.

RGC:GH:gls
IOR-2019-15110

Attachments

c: Arlene Barrera, Auditor-Controller
Audit Committee
Audit Division

DEPARTMENT OF MENTAL HEALTH
IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2019-15110

TABLE OF FINDINGS AND RECOMMENDATIONS FOR CORRECTIVE ACTION

	ISSUE	RISK	RECOMMENDATION	P[1]	SUMMARY OF RESPONSE
1	**Mail Tracking:** Department of Mental Health (DMH) Office of the Public Guardian (PG) mailroom staff do not consistently log DMH mail when it is opened and found to contain items of value (e.g., cash, checks, wills) as required by DMH Policy 124. We also noted that PG staff routinely receive, and forward mail addressed to other departments that may contain valuables, but do not have an effective mechanism to log/track non-PG correspondence/parcels or their subsequent transfer to the intended recipient.	Inadequate controls over mail handling create the risk that packages containing valuable property and currency may be lost, stolen, or mishandled.	**DMH management:** **a. Revise DMH Policy 124 to require the mail log to identify the staff opening mail in dual-custody, and expand the mail log to include:** • **Any mail sent with a tracking identifier (i.e. registered, certified); and** • **Any misdirected mail received in the mailroom for recipients in other departments;** **b. Implement a formal mechanism to document the transfer of mail from PG to other departments;** **c. Consider options for maintaining mail tracking logs electronically; and** **d. Distribute the revised policy and procedures to impacted staff and obtain documentation of their understanding and agreement to comply with it.**	1	**Agree,** Target Implementation Date: March 10, 2020 DMH's response indicates they will implement internal controls over the mailroom procedures in areas noted in the review.

[1] **Priority Ranking:** Recommendations are ranked from Priority 1 to Priority 3 based on the potential seriousness and likelihood of negative impact on departmental operations if corrective action is not taken. See Attachment IV for definitions of priority rankings.

TABLE OF FINDINGS AND RECOMMENDATIONS FOR CORRECTIVE ACTION					
	ISSUE	RISK	RECOMMENDATION	P[1]	SUMMARY OF RESPONSE
2	**Mailroom Security:** We noted opportunities for DMH PG to strengthen physical security controls over the mailroom. For example, the mailroom is sometimes left unattended during business hours, that the PG mailroom does not have a locking mailbox where postal carriers can deposit/deliver parcels when mailroom staff are not present, and mail/packages are left outside the mailroom in an unsecured area accessible by anyone housed within the PA office area. We also noted that the PG does not have surveillance cameras in the mail handling/storage areas.	The lack of physical security controls increases the risk that valuable mail and packages directed to the PG may be lost or stolen.	**DMH management strengthen physical security controls over the PG mailroom.**	1	**Agree** Target Implementation Date: April 10, 2020 DMH's response indicates they will implement security controls as well as work with the Department's labor partners to modify affected staff working conditions. DMH agrees and is working to enhance mailroom security controls as quickly as possible. Additional time is needed to vet some of the control measures and work process changes with the Department's labor partners, and we agreed that it would be reasonable to extend the implementation timeframe for this Priority 1 recommendation to 120 days.

[1] **Priority Ranking:** Recommendations are ranked from Priority 1 to Priority 3 based on the potential seriousness and likelihood of negative impact on departmental operations if corrective action is not taken. See Attachment IV for definitions of priority rankings.

FOLLOW-UP AND INTERNAL CONTROL DISCLOSURES

FOLLOW-UP PROCESS

The Auditor-Controller (A-C) has a follow-up process designed to provide assurance to the Board of Supervisors (Board) that departments are taking appropriate and timely corrective action to address audit recommendations. Within six months of the date of an audit report, departments must submit a Corrective Action Implementation Report (CAiR) detailing the corrective action taken to address all recommendations in the report. Departments must also submit documentation with the CAiR that demonstrates the corrective action taken. We will review departments' reported corrective action and supporting documentation, and report the results to the Board. For any recommendations not fully implemented, departments must report the status of corrective action within six months after our first follow-up report is issued.

MANAGEMENT'S RESPONSIBILITY FOR INTERNAL CONTROLS

As indicated in County Fiscal Manual Section 1.0, management of each County department is primarily responsible for designing, implementing, and maintaining a system of internal controls that provides reasonable assurance that important departmental and County objectives are being achieved. Internal controls should sustain and improve departmental performance, adapt to changing priorities and operating environments, reduce risks to acceptable levels, and support sound decision-making.

Management must monitor internal controls on an ongoing basis to ensure that any weaknesses or non-compliance are promptly identified and corrected. The A-C's role is to assist management by performing periodic assessments of the effectiveness of the department's internal control systems. These assessments complement, but do not in any way replace, management's responsibilities over internal controls.

LIMITATIONS OF INTERNAL CONTROLS

Any system of internal controls, however well designed, has limitations. As a result, internal controls provide reasonable but not absolute assurance that an organization's goals and objectives will be achieved. Some examples of limitations include errors, circumvention of controls by collusion, management override of controls, and poor judgment. In addition, there is a risk that internal controls may become inadequate due to changes in the organization, such as reduction in staffing or lapses in compliance.

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer
Clinical Operations

Gregory C. Polk, M.P.A.
Chief Deputy Director
Administrative Operations

December 10, 2019

TO: Robert G. Campbell, Chief
Office of County Investigations

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **RESPONSE TO AUDITOR-CONTROLLER FINDINGS AND RECOMMENDED CORRECTIVE ACTIONS – REPORT #2019-15110**

The Department has reviewed the Auditor-Controller's report and agrees with the findings and recommendations. Attached is the Department's plan of corrective action.

If you have any questions, please contact me at (213) 738-4601, or your staff may contact Connie D. Draxler, Deputy Director, Office of the Public Guardian, at (213) 974-0407.

JES:CD:lm

Attachment

DEPARTMENT OF MENTAL HEALTH
IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2019-15110
DEPARTMENT ACTION PLAN/RESPONSE

ISSUE 1: MAIL TRACKING	
A/C Recommendation	DMH management: a) Revise DMH Policy 124 to require the mail log to identify the staff opening mail in dual-custody, and expand the mail log to include: • Any mail sent with a tracking identifier (i.e. registered, certified, etc.); and • Any misdirected mail received in the mailroom for recipients in other departments. b) Implement a formal mechanism to document the transfer of mail from PG to other departments; c) Consider options for maintaining mail tracking logs electronically; and d) Distribute the revised policy and procedures to impacted staff and obtain documentation of their understanding and agreement to comply with it.
Priority	**PRIORITY 1**
Agree/Disagree	**Agree**
Department Action Plan[1]	The Department of Mental Health/Office of the Public Guardian will update the Office of Public Guardian (OPG) Policy 124, Mail Processing, to include these new requirements: • Employees working in the mailroom to log their name when opening mail in dual custody • Log in all mail with a tracking identifier (registered mail, certified mail) • Log in all misdirected mail received for other departments including Treasurer-Tax Collector/Public Administrator office. OPG will develop a Receipt/Acknowledgement Form for mail received for other departments. The form will be signed when the other department picks up the misdirected mail. OPG will use manual logs initially but will explore the possibility of maintaining electronic logs if the electronic logs can demonstrate an increased efficiency to the manual logs. OPG will distribute the updated policy 124 to all Public Guardian staff.
Planned Implementation Date	March 10, 2020

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[1] In this section the Department should only describe the efforts they plan to take to implement the recommendation. Any other information should be included in the Additional Information section below.
[2] In this section the Department can provide any background or clarifying information they believe is necessary.

ISSUE 2: MAILROOM SECURITY	
A/C Recommendation	DMH management strengthen physical security controls over the PG mailroom.
Priority	PRIORITY 1
Agree/Disagree	Agree
Department Action Plan[1]	The Department of Mental Health/Office of the Public Guardian will require employees assigned to the mailroom to alternate their breaks and lunch so the mailroom is open and available during business hours for any mail deliveries. The addition of surveillance cameras will require DMH to meet with SEIU because this is a change in working conditions. DMH will set up the meeting within 60 days to explore the addition of the cameras. Additionally, DMH will evaluate the capacity for the department to monitor the surveillance cameras.
Planned Implementation Date	April 10, 2020

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[1] In this section the Department should only describe the efforts they plan to take to implement the recommendation. Any other information should be included in the Additional Information section below.
[2] In this section the Department can provide any background or clarifying information they believe is necessary.

PRIORITY RANKING DEFINITIONS

Auditors use professional judgment to assign rankings to recommendations using the criteria and definitions listed below. The purpose of the rankings is to highlight the relative importance of some recommendations over others based on the likelihood of adverse impacts if corrective action is not taken and the seriousness of the adverse impact. Adverse impacts are situations that have or could potentially undermine or hinder the following:

a) The quality of services departments provide to the community,
b) The accuracy and completeness of County books, records, or reports,
c) The safeguarding of County assets,
d) The County's compliance with pertinent rules, regulations, or laws,
e) The achievement of critical programmatic objectives or program outcomes, and/or
f) The cost-effective and efficient use of resources.

Priority 1 Issues

Priority 1 issues are control weaknesses or compliance lapses that are significant enough to warrant immediate corrective action. Priority 1 recommendations may result from weaknesses in the design or absence of an essential procedure or control, or when personnel fail to adhere to the procedure or control. These may be reoccurring or one-time lapses. Issues in this category may be situations that create actual or potential hindrances to the department's ability to provide quality services to the community, and/or present significant financial, reputational, business, compliance, or safety exposures. Priority 1 recommendations require management's immediate attention and corrective action within 90 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.

Priority 2 Issues

Priority 2 issues are control weaknesses or compliance lapses that are of a serious nature and warrant prompt corrective action. Priority 2 recommendations may result from weaknesses in the design or absence of an essential procedure or control, or when personnel fail to adhere to the procedure or control. These may be reoccurring or one-time lapses. Issues in this category, if not corrected, typically present increasing exposure to financial losses and missed business objectives. Priority 2 recommendations require management's prompt attention and corrective action within 120 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.

Priority 3 Issues

Priority 3 issues are the more common and routine control weaknesses or compliance lapses that warrant timely corrective action. Priority 3 recommendations may result from weaknesses in the design or absence of a procedure or control, or when personnel fail to adhere to the procedure or control. The issues, while less serious than a higher-level category, are nevertheless important to the integrity of the department's operations and must be corrected or more serious exposures could result. Departments must implement Priority 3 recommendations within 180 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.