STATE OF CONNECTICUT

AUDITORS' REPORT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
FOR THE FISCAL YEARS ENDED JUNE 30, 2017 AND 2018

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ ROBERT J. KANE

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August 6, 2020

EXECUTIVE SUMMARY

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes, we have audited certain operations of the Department of Mental Health and Addiction Services (DMHAS). The objectives of this review were to evaluate the department's internal controls, compliance with policies and procedures, as well as certain legal provisions, and management practices and operations for the fiscal years ended June 30, 2017 and 2018.

The key findings are presented below:

Page 21	There are weaknesses in the systematic process and fiscal monitoring of programs administered by private providers. The Department of Mental Health and Addiction Services (DMHAS) should strengthen internal controls over its monitoring of private providers. The department should ensure that it has formal procedures in place, and document its monitoring efforts. (Recommendation 12.)
Page 14	Overtime is excessive and inadequately tracked and monitored. The Department of Mental Health and Addiction Services should strengthen internal controls over overtime to ensure compliance with policies and procedures. The department should adequately track and monitor overtime. (Recommendation 6.)
Page 35	There was no evidence that 2,307 hours of timekeeper overtime were properly requested, approved, and justified. The Department of Mental Health and Addiction Services should create a system to document its timekeeper overtime requests, approvals, and equalization efforts. (Recommendation 23.)
Page 35	The department paid $37,728 for 8 months of electricity at a building that a local mental health authority no longer leased. The Department of Mental Health and Addiction Services should ensure that local mental health authorities promptly notify all appropriate parties of location changes. (Recommendation 22.)
Page 32	The department has $48,825 in client funds that have been inactive since at least 2013. The Department of Mental Health and Addiction Services should make every effort to return unspent client funds to the rightful owners and escheat unclaimed funds to the Office of the State Treasurer. (Recommendation 20.)
Page 33	There are weaknesses in the administration of client support funds. The Department of Mental Health and Addiction Services should strengthen internal controls over Young Adult Services client support funds to ensure compliance with established policies and procedures. (Recommendation 21.)
Page 30	There are weaknesses in the management of client funds. The Department of Mental Health and Addiction Services should strengthen internal controls over client funds to ensure compliance with established policies and procedures. (Recommendation 19.)
Page 27	There are weaknesses in the administration of trustee accounts. The Department of Mental Health and Addiction Services should strengthen internal controls over trustee accounts to ensure compliance with established policies and procedures. (Recommendation 17.)

STATE OF CONNECTICUT

AUDITORS OF PUBLIC ACCOUNTS
State Capitol
210 Capitol Avenue
Hartford, Connecticut 06106-1559

JOHN C. GERAGOSIAN

ROBERT J. KANE

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AUDITORS' REPORT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
FOR THE FISCAL YEARS ENDED JUNE 30, 2017 AND 2018

We have audited certain operations of the Department of Mental Health and Addiction Services in fulfillment of our duties under Section 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the years ended June 30, 2017 and 2018. The objectives of our audit were to:

1. Evaluate the department's internal controls over significant management and financial functions;

2. Evaluate the department's compliance with policies and procedures internal to the department or promulgated by other state agencies, as well as certain legal provisions; and

3. Evaluate the effectiveness, economy, and efficiency of certain management practices and operations, including certain financial transactions.

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the department, as well as certain external parties; and testing selected transactions. We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contracts, grant agreements, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We conducted our audit in accordance with the standards applicable to performance audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying Résumé of Operations is presented for informational purposes. This information was obtained from various available sources, including but not limited to, the department's management and the state’s information systems, and was not subjected to the procedures applied in our audit of the department. For the areas audited, we identified:

1. Deficiencies in internal controls.

2. Apparent noncompliance with policies and procedures or legal provisions; and

3. Need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors’ Findings and Recommendations in the accompanying report presents any findings arising from our audit of the Department of Mental Health and Addiction Services.

COMMENTS

FOREWORD

The Department of Mental Health and Addiction Services (DMHAS) operates under the provisions of Title 17a, Chapters 319i and 319j and Sections 17a-450 through 17a-715 of the General Statutes. The department’s mission is to promote recovery from psychiatric and substance use disorders by providing an integrated network of comprehensive, effective, and efficient mental health and addiction services that foster self-sufficiency, dignity, and respect. The department’s mandate is to serve adults older than 18 years of age with psychiatric or substance use disorders who lack the financial means to obtain services on their own. In addition to its mandate, the department provides collaborative treatment programs to Connecticut residents with co-occurring mental health and substance use disorders, individuals in the criminal justice system, persons with traumatic brain injury, and young adult populations transitioning out of the Department of Children and Families. DMHAS is designated as the lead state agency for substance abuse prevention and treatment, and as such, is designated as the state methadone authority.

Organizational Structure

During the audited period, the commissioner of DMHAS managed the department’s operations through 4 major divisions: Agency Management, Clinical Support, Community Treatment and Prevention, and Health Promotion. The Agency Management Division conducts comprehensive statewide planning, data collection, policy analysis, and provides administrative and financial management. The Clinical Support Division manages inpatient services and recovery support services. The Community Treatment Division focuses on outpatient programs, emergency crisis services, residential treatments, and housing assistance programs. The Prevention and Health Promotion Division provides advocacy services, education, training, and research.

DMHAS has divided the state into regions and catchment areas to deliver mental health and substance abuse treatment services. There are 5 regions containing 23 catchment areas. Each catchment area, which is a defined geographic area based on population, receives mental health

services as a unit, and is assigned to a local mental health authority (LMHA). As of June 30, 2018, there were 13 local mental health authorities in effect, 6 state-operated and 7 private nonprofit organizations. The 6 state-operated LMHAs provide mental health services as well as manage and fund a network of private nonprofit agencies in their respective geographic regions. The five regions are:

- **Region 1 –** Southwest Connecticut Mental Health System (SWCMHS), including the F.S. DuBois Center and the Greater Bridgeport Community Mental Health Center, which serves lower Fairfield County.

- **Region 2 –** Connecticut Mental Health Center (CMHC), which serves the New Haven area. River Valley Services (RVS), which serves Middlesex County.

- **Region 3 –** Southeastern Mental Health Authority (SMHA), which serves New London County.

- **Region 4 –** Capitol Region Mental Health Center (CRMHC), which serves the Hartford area.

- **Region 5 –** Western Connecticut Mental Health Network (WCMHN) – an umbrella unit that oversees the (1) Waterbury Mental Health Authority, which serves Northern New Haven County, (2) Danbury Mental Health Authority, which serves Northern Fairfield County, and (3) Torrington Mental Health Authority, which serves Litchfield County.

The 7 local mental health authorities operated by private nonprofit organizations are funded through DMHAS grants. They maintain community-based network systems for mental health and addiction services in areas not covered by state-operated facilities.

DMHAS also operates 5 treatment facilities that provide inpatient psychiatric and/or substance abuse treatment services:

- Connecticut Valley Hospital in Middletown
- Whiting Forensic Hospital in Middletown
- Connecticut Mental Health Center in New Haven
- Greater Bridgeport Community Mental Health Center in Bridgeport
- Capitol Region Mental Health Center in Hartford

Commissioner Miriam E. Delphin-Rittmon was appointed by Governor Dannel P. Malloy on March 30, 2015, and continues to serve in that capacity.

Legislative Changes

Governor Dannel P. Malloy's Executive Order No. 63, signed December 29, 2017, instructed DMHAS to separate the Whiting Forensic Division and the Dutcher Enhanced Security Building from Connecticut Valley Hospital (CVH) and form Whiting Forensic Hospital (WFH). Whiting Forensic Hospital was officially established as an independent division on May 1, 2018, and is

comprised of 91 maximum-security beds at Whiting Service and 138 enhanced security beds at Dutcher Service.

Public Act 18-86, effective June 4, 2018, made various changes to the General Statutes related to DMHAS facilities, primarily Connecticut Valley Hospital and Whiting Forensic Hospital. Specifically, it:

- Established an 8-member task force to, among other things, review and evaluate DMHAS facility operations and conditions;
- Established mandatory reporting of suspected patient abuse, and related reporting requirements and penalties;
- Required the commissioner of DMHAS to investigate reports of suspected abuse and establish related requirements, such as disclosure of, and access to, patient abuse reports and investigations;
- Required the Department of Public Health (DPH) to conduct an on-site inspection and records review of Whiting Forensic Hospital and report the outcome to the Public Health Committee and DMHAS task force; and
- Subjected Whiting Forensic Hospital to DPH licensure and regulation, which it was previously exempt from, and made minor technical changes to reflect the hospital's separation from Connecticut Valley Hospital pursuant to Executive Order No. 63.

Boards and Commissions

Board of Mental Health and Addiction Services:

Pursuant to Sections 17a-456 and 17a-457 of the General Statutes, the Board of Mental Health and Addition Services consists of members appointed by the Governor, Regional Mental Health Board chairs and their designees, and designees from the Regional Action Councils for substance abuse. The board meets monthly with the commissioner of DMHAS and advises the commissioner on programs, policies, and plans for the department.

Psychiatric Security Review Board:

Pursuant to Sections 17a-580 through 17a-603 of the General Statutes, the Psychiatric Security Review Board is an autonomous body within DMHAS for administrative purposes only. The board is composed of 6 members appointed by the Governor and confirmed by either house of the General Assembly. The board's mission is to protect the safety of Connecticut citizens by ordering treatment, confinement, or conditional release of persons acquitted of a crime by reason of mental disease or defect.

RÉSUMÉ OF OPERATIONS

DMHAS programs served 106,906 individuals during the 2016-2017 fiscal year and 105,540 individuals during the 2017-2018 fiscal year. The operations of the department, which were primarily accounted for in the General Fund and the Federal and Other Restricted Accounts Fund, are discussed below.

General Fund

Receipts:

A comparison of General Fund receipts during the audited period, along with those of the preceding year, follows:

	2015-2016	2016-2017	2017-2018
Rental of Cottages or Residences	$46,969	$38,508	$36,529
Refund of Prior Years' Expenditures	2,611,662	3,317,615	326,794
All Other	79,353	61,682	30,992
Total Receipts	**$2,737,984**	**$3,417,805**	**$394,315**

General Fund receipts consisted primarily of refunds of prior years' expenditures and fees for the rental of cottages and residences to employees. The significant decrease in receipts from the 2016-2017 fiscal year to the 2017-2018 fiscal year is due primarily to delays in reviews of providers' single audit reports, which determine the balances due from providers. This responsibility has since been transferred from the Fiscal Division to the Internal Audit Division.

Expenditures:

A summary of General Fund expenditures, including expenditures of the Psychiatric Security Review Board, for the fiscal years under review and the preceding year follows:

	2015-2016	2016-2017	2017-2018
Personal Services and Employee Benefits	$312,888,043	$298,276,807	$292,015,249
Workers' Compensation	11,628,890	11,563,126	13,832,161
Contractual Services	35,273,890	31,162,420	34,302,627
Client Services	15,153,700	268,794,324	251,337,567
Premises and Property Expenses	13,396,122	12,536,329	13,268,763
Information Technology	4,066,902	2,665,448	3,481,405
Purchased Commodities	14,269,497	12,879,870	12,883,499
Fixed Charges	304,348,950	40,818,814	48,016,247
All Other	5,645,705	5,161,457	5,018,016
Subtotal	$716,671,699	$683,858,595	$674,155,534
Medicaid Disproportionate Share Payments	(79,818,547)	(79,818,547)	(79,818,547)
Total Expenditures	**$636,853,152**	**$604,040,048**	**$594,336,987**

The General Fund is the department's principal source of operation, and includes all expenditures that do not have to be accounted for in a specified fund. The majority of General Fund expenditures were for personal services and payments to contractors providing client mental health and addiction services. In the 2016-2017 fiscal year, the department began recording contract payments as "client services" rather than "fixed charges," which account for the fluctuations within those categories.

During the audited period, the department received annual disproportionate share payments of $79,818,547. These Medicaid reimbursements were permitted by an approved amendment to the state's Medicaid plan under Section 1923(c)(3) of the Social Security Act. The amendment provided payment adjustments to the state for the cost of care for uninsured low-income persons in certain state-operated psychiatric hospitals. The department applied disproportionate share deposits as reductions to General Fund expenditures. DMHAS credited $29,116,453 in reimbursements related to fringe benefits for each year to the State Comptroller's accounts.

Federal and Other Restricted Accounts Fund

Receipts:

A comparison of Federal and Other Restricted Accounts receipts for the fiscal years under review and the preceding year follows:

	2015-2016	2016-2017	2017-2018
Federal Aid	$54,242,588	$68,307,282	$61,492,891
Non-Federal Aid	19,871,991	12,410,477	13,170,023
Grant Transfers	440,872	642,718	323,550
Investment Interest	831	5,611	2,703
Total Receipts	**$74,556,282**	**$81,366,088**	**$74,989,167**

Federal and Other Restricted Accounts Fund receipts were primarily for federal grants. The Continuum of Care program, Community Mental Health Services block grant, and Substance Abuse Prevention and Treatment block grant accounted for the majority of federal grant receipts. The department received $91,894,802 in receipts for these grants during the audited period. The fluctuations in federal grant receipts were caused by timing differences in the drawdowns of federal funds.

Expenditures:

A summary of the department's Federal and Other Restricted Accounts Fund expenditures follows:

	2015-2016	2016-2017	2017-2018
Personal Services and Employee Benefits	$1,427,616	$1,429,732	$1,176,018
Contractual Services	2,337,751	2,698,708	1,773,821
Client Services	17,272,235	72,244,358	70,174,763
Premises and Property Expenses	52,657	22,719	8,044

Information Technology	84,480	87,130	128,553
Purchased Commodities	23,273	64,675	239,621
Fixed Charges	50,332,166	3,708,762	4,620,970
All Other	133,621	(528,774)	(84,624)
Total Expenditures	**$71,663,799**	**$79,727,310**	**$78,037,166**

Federal and Other Restricted Accounts Fund expenditures were primarily for payments made to contractors providing various mental health and addiction services to clients. In the 2016-2017 fiscal year, the department began recording contract payments as "client services" rather than "fixed charges", which accounts for the fluctuations within those categories. The increase in expenditures from the 2015-2016 fiscal year to the 2016-2017 fiscal year was due primarily to an increase in funding for the federal Continuum of Care program.

Special Revenue Funds

In addition to activities in the General Fund and Federal and Other Restricted Accounts Fund, the department was authorized to spend special revenue and capital project funds, which were used to finance activities in accordance with specific state laws and regulations. DMHAS financed these funds with bond sale proceeds or through specific state revenue dedicated to the renovation of state-owned facilities and capital improvement grants to nonprofit organizations in the DMHAS provider network. Expenditures in the audited fiscal years and those of the preceding fiscal year are summarized below.

	2015-2016	2016-2017	2017-2018
Capital Equipment Purchase Fund	$1,287,804	$869,821	$2,080,721
Bond Fund for Non-Profits' Capital Improvements	1,652,532	1,572,961	1,117,555
Bond Fund for Capital Improvements and Others	1,418,943	3,318,721	1,939,229
Insurance Fund	397,299	408,924	408,924
Community Conservation & Development	2,517,973	1,651,287	6,021,695
Total Expenditures	**$7,274,551**	**$7,821,714**	**$11,568,124**

The increase in special revenue expenditures from the 2016-2017 fiscal year to the 2017-2018 fiscal year is primarily due to upgrades at Connecticut Valley Hospital. The department also took over a bond fund previously held by the Department of Social Services. During the audited period, the DMHAS Centralized Contracts Unit disbursed bond funds to municipalities and non-profit agencies for various capital improvements, including energy efficiency enhancements at the Plainville Food Pantry, a roof replacement at Stamford YMCA, and the construction of a new senior center in Southington.

Inpatient Per Capita Costs

Under the provisions of Sections 17b-222 and 17b-223 of the General Statutes, the State Comptroller determines annual per capita costs for the care of persons in the 3 inpatient facilities

that meet the definition of a state humane institution. The per capita costs for the inpatient care during the audited period were as follows:

	2016-2017		2017-2018	
	Daily	**Annual**	**Daily**	**Annual**
Connecticut Valley Hospital	$1,618	$590,570	$1,500	$547,500
Connecticut Mental Health Center	2,526	921,990	2,437	889,505
Southwest Connecticut Mental Health System	2,146	783,290	1,915	698,975

The inpatient per capita rates decreased for all 3 facilities from the 2016-2017 fiscal year to the 2017-2018 fiscal year. During the 2017-2018 fiscal year, inpatient costs and days of service decreased at Connecticut Valley Hospital and Connecticut Mental Health Center, but increased modestly at Southwest Connecticut Mental Health System. The roll-forward credit adjustments in the 2017-2018 fiscal year resulted in decreased per capita rates for all 3 facilities.

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Our examination of the records of the Department of Mental Health and Addiction Services disclosed the following 23 findings and recommendations, of which 20 have been repeated from the previous audit:

Improper Approval of Compensatory Time

Criteria: The department's timekeeping policy requires the authorization and advance approval of all compensatory time.

Condition: Our review of compensatory time identified the following conditions:

- Supervisors did not adequately document approval of 53 hours for two employees' compensatory time. There was no supervisor signature for either employee, and the department did not document one employee's approval date.
- Prior supervisory approval was not obtained for 6 employees' 161 hours of compensatory time. The employees obtained approval between 4 and 623 days after the pay period.

Context: During the audited period, 2,056 employees earned a total of 140,809 hours of compensatory time. We reviewed 276 hours of compensatory time earned by 10 employees.

Effect: There is an increased risk for compensatory time to be improperly earned.

Cause: The lack of proper approvals appears to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that compensatory time is properly approved and documented. (See Recommendation 1.)

Agency Response: "Effective January 1, 2016, DMHAS implemented a process where the Director of Payroll runs reports that identify all agency employees who earned compensatory time. A random sample, from the reports, is selected. A request is forwarded to the facility Human Resources office, and leadership, to provide copies of the preapproved requests to earn compensatory time to the Payroll Director. Once reviewed and deemed

appropriate, copies of the preapproved requests are retained and stored electronically by the agency Payroll Director."

Lack of Separation of Procedures for Terminated Employees

Criteria: Sound business practice provides that state agencies have standard procedures and forms to ensure that the separation process is completed and documented for all terminated employees.

Condition: The department had no documentation on file indicating that it completed the separation process for the 10 terminated employees we reviewed.

Context: During the audited period, 732 employees separated from the department. We selected 10 terminated employees for our review.

Effect: The lack of standardized separation procedures and forms increases the risk that former employees did not return state property. It also increases the risk that the department did not deactivate building and system access, and did not submit required forms upon an employee's separation.

Cause: During the audited period, the department did not have standard procedures and forms in place to document the separation process for terminated employees.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should establish procedures to ensure that the employee separation process is completed and adequately documented. (See Recommendation 2.)

Agency Response: "Effective May 3, 2019, DMHAS established procedures to ensure that the employee separation process is documented. Human Resources staff will be responsible for making sure that a completed Separation Checklist is filed in each terminated employee's personnel file, which will also account for the return of all state property."

Inadequate Workers' Compensation Records

Criteria: The Department of Administrative Services' (DAS) Workers' Compensation Program provides state agencies and employees with the information and tools necessary for the uniform administration of the program. The DAS Workers' Compensation Manual requires the

completion of a workers' compensation claim packet, and provides details on how to enter claims into Core-CT.

Condition: Our review of workers' compensation claims identified the following conditions:

- One claim was not supported by a complete workers' compensation package and was missing 3 forms.
- The department inaccurately recorded dates and time reporting codes for 4 claims. The inaccurate dates resulted in 3 employees being underpaid by $846.

Context: During the audited period, 1,268 workers' compensation claims were filed by department employees. We reviewed 10 claims.

Effect: There is an increased risk for processing errors and inaccurate payments.

Cause: The identified conditions appear to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure workers' compensation claims are supported and accurately recorded. (See Recommendation 3.)

Agency Response: "The Workers' Compensation Unit will ensure all proper documentation is on file prior to submitting claims to the state's Third Party Administrator. The agency has reinstituted a past process where all timesheets that reflect Time Reporting Codes (TRC's) related to workers' compensation be properly labeled. The agency authorized the DMHAS Information Technology Department to build a database to monitor all workers' compensation claims reported in DMHAS. This database tracks receipt of individual forms and has a feature that negates any further processing until all required forms are received in the DMHAS Workers' Compensation Unit. This database was completed and brought online in May 2017. The DMHAS Workers' Compensation Unit staff attended training presented by the Department of Administrative Services which included workers' compensation claim processing."

Inadequate Medical Leave Records

Criteria: Section 5-247-11 of the state personnel regulations, and most collective bargaining agreements, require employees to submit a medical certificate to substantiate 5 or more consecutive days of sick leave. The statewide Family and Medical Leave Policy sets forth procedures for requesting leave under the Family and Medical Leave Act (FMLA). The policy outlines the required forms and submission deadlines.

Condition: Our review of medical leaves identified the following conditions:

- Required forms were missing or inadequate for 6 employees on 152 days of medical leave. One employee's medical certificate did not cover the leave period. Required FMLA forms for 5 employees were missing, and one employee's fitness for duty report was missing.

- The department did not promptly complete required FMLA documentation for 2 employees on medical leave for 154 days. The department received employee FMLA requests and other related information, but did not complete the required forms until 85 to 124 days later, after the employees returned to work.

Context: During the audited period, 1,089 employees were on medical leave for more than 5 consecutive days for a total of 176,546 hours, or 22,068 days. We reviewed 10 employees on medical leave for a total of 2,237 hours, or 286 days.

Effect: The lack of adequate documentation reduces the assurance that medical leaves are appropriate.

Cause: These conditions appear to be the result of oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure medical leave is administered in accordance with collective bargaining agreements and Family and Medical Leave Act guidelines. (See Recommendation 4.)

Agency Response: "Effective January 1, 2016, DMHAS has implemented an internal process where the Director of Payroll runs periodic reports for employees who were out 5 or more consecutive scheduled work days and verifies that proper documentation is on file. This assists in the notification to Human Resources that employees are out on leave and

the Human Resources Facility liaison can notify the employee of their entitlements.

In regards to the agency not completing the required FMLA documentation in a timely manner, due to the staffing shortages at the FMLA Unit, the agency has begun shifting the responsibility back to the local Human Resources liaisons at the state facilities in order to be in compliance with the regulations."

Improper Coding of Holiday Time

Background: Employees record scheduled holidays on their timesheets. While generally not the case, in some instances it is appropriate for employees to record holiday time on non-holidays. For example, employees working a third shift at 24-hour facilities would record holiday time on the day following the scheduled holiday.

Criteria: Proper internal controls dictate that supervisors should review and approve employee timesheets at the end of each pay period to ensure they are accurate and complete. Employees and supervisors should promptly correct reported time errors.

Condition: We noted that 9 employees incorrectly recorded 76 hours of holiday time on non-holidays. During our review, the department changed time reporting codes, adjusted leave accruals, and collected overpayments from 7 employees. The department sent letters seeking reimbursement from the other 2 employees, but they had yet to respond at the time of our review.

Context: During the audited period, 494 employees charged a total of 20,507 hours of holiday time on non-holidays. We reviewed 10 employees that charged a total of 84 hours of holiday time on non-holidays.

Effect: Attendance records were inaccurate and the department did not collect overpayments in some cases.

Cause: These issues appear to be the result of inadequate supervisory timesheet reviews.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that holiday time is accurately recorded. (See Recommendation 5.)

Agency Response: "Effective December 20, 2016, DMHAS implemented a new policy titled "Time Keeping for DMHAS Employees." This policy outlines various payroll related audit reports which assist supervisors in the proper approval of employee timesheets."

Weaknesses in the Administration of Overtime

Criteria: The department's timekeeping policy requires the authorization and advance approval of all overtime. The department should maintain adequate documentation to support overtime.

To adequately track and monitor overtime, the department should code the time to the units the employee worked.

Collective bargaining agreements require that overtime be distributed equally among qualified volunteers with similar skills and duties. The department should document its overtime equalization efforts.

Sound business practice calls for policies and procedures to monitor employee overtime to prevent adverse effects on the quality of care and client safety.

Condition: Our review of overtime identified the following conditions:

- For 339 hours of overtime earned by 7 employees, the department did not document 77.25 hours.
- For 192.5 hours of overtime earned by 5 employees, overtime requests and approvals were not on file or not properly approved for 177 hours.
- Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH) do not code overtime to the units the employees actually worked. CVH and WFH record all overtime to the employees' assigned units in the payroll system.
- For 192.5 hours of overtime earned by 5 employees, the department did not have documentation on file to support the equalization of overtime.
- Five employees earned excessive overtime. These employees worked more than 30 consecutive days on 14 occasions in fiscal year 2017 and 16 occasions in fiscal year 2018. Additionally, 4 of the

employees earned more than double their annual base salaries in both fiscal years.

Context: During the audited period, 2,699 employees earned a total of $102,213,466 in overtime. We selected 20 employees from Connecticut Valley Hospital and Whiting Forensic Hospital who earned a total of $38,785, or 888.75 hours, in overtime.

Effect: The lack of documentation and approvals increases the risk for improper overtime payments. Without adequate controls in place for overtime tracking and equalization, overtime costs may not be effectively managed and controlled. . When employees work excessive overtime, there may be negative effects on the quality of care and the safety of clients and employees.

Cause: The complexity of the department's workforce, staffing shortages, and a lack of oversight by management appear to have contributed to these conditions.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls for overtime to ensure compliance with policies and procedures. The department should adequately track and monitor overtime. (See Recommendation 6.)

Agency Response: "In August 2019, Whiting Forensic Hospital (WFH) notified all bargaining unit personnel that the hospital would be adhering to previously issued guidelines that prior authorization be approved for requesting overtime. All requests are made to the respective WFH Chief Medical, Nursing, and Operations Officers along with a copy to the CEO. This process ensures that staffing needs are met internally before allowing WFH staff to work at another state-operated facility. This has assisted in better managing overtime.

Moreover, during the spring of 2020, DMHAS will be installing an electronic timekeeping system, which will fully automate this function. This system will assist WFH in managing overtime and maintaining precise documentation of hours worked."

Failure to Adjust Leave in Lieu of Accrual

Criteria: Agencies are allowed to temporarily use the Leave in Lieu of Accrual (LILA) time reporting code until monthly leave accruals or compensatory leave hours are posted to an employee's leave time balance. Core-CT Job Aid procedures require state agencies to review monthly usage of LILA time reporting codes and adjust these hours to the appropriate leave accrual balances. If an employee does not have sufficient leave accruals, the department should seek reimbursement.

Condition: Our review identified the following conditions:

- We noted 5 instances in which the department should have redistributed 39 hours of LILA time to the appropriate leave accrual balances once the leave time became available. The department adjusted leave accruals and collected overpayments between 5 and 25 months after the time was reported.

- We noted one instance in which 8 hours of the LILA time reporting code was applied, but the department had not corrected it over a year later.

Context: During the audited period, there were 48 instances in which 317.5 hours were charged to the LILA time reporting code. We reviewed 10 instances in which 76.75 hours were charged to the LILA time reporting code.

Effect: Lack of monitoring of the use of the LILA time reporting code could result in employees using more leave time than they earned.

Cause: This appears to be the result of an oversight by management in the monitoring of the LILA time reporting code.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should ensure that the LILA time reporting code is adjusted in accordance with Core-CT Job Aid procedures. (See Recommendation 7.)

Agency Response: "As previously mentioned, DMHAS implemented a new policy titled "Time Keeping for DMHAS Employees." This policy outlines various payroll related audit reports that are required to be run during the payroll cycle, of which LILA is included, and continues to correct all deficiencies in this area."

Lack of Approval for Paid Administrative Leave

Criteria: Section 5-240-5a of the state personnel regulations permits state agencies to place employees on paid administrative leave for up to 30 days in cases involving pending criminal charges. An additional 30 days may be granted with the approval of the Commissioner of Administrative Services.

According to Article 33, Section 7 of the New England Health Care Employees Union (1199) bargaining unit contract, if an agency determines that there are extenuating circumstances to extend paid administrative leave beyond 60 days, the agency must obtain prior approval from the Office of Labor Relations (OLR).

Condition: Our review of 10 employees on paid administrative leave for more than 30 days identified the following conditions:

- For all 10 employees, the department did not obtain the commissioner of Administrative Services' approval to extend the leave for an additional 30 days.
- Three employees were on paid administrative leave for 125 to 198 days, which is beyond the 60 days allowed.
- For the seven 1199 employees on leave for more than 60 days, the department did not obtain the Office of Labor Relations' approval to extend their leave.

Context: During the audited period, 92 employees charged a total of 53,024 hours to paid administrative leave. We selected 10 employees who charged a total of 14,620 hours to paid administrative leave. The employees were on paid administrative leave for 166 to 258 days.

Effect: There is an increased risk for the department to incur potentially unnecessary costs for paid administrative leave.

Cause: The lack of approvals appears to be the result of an oversight by management and the nature and complexity of the investigations.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should comply with state personnel regulations and bargaining unit contracts when placing employees on paid administrative leave. (See Recommendation 8.)

Agency Response: "A DMHAS process has been enhanced to include the DMHAS Labor Relations Division on the daily Core-CT list of employees on a "Leave of Absence." This report provides the necessary reminder that all contractual and/or statutory deadlines are approaching and a possible extension authorized by Office of Labor Relations may be necessary. DMHAS redirected Human Resources support staff to the DMHAS Office of Labor Relations effective October 2017 to ensure compliance."

Inadequate Records to Support Extended Working Test Periods

Criteria: The Department of Administrative Services' General Letter No. 31 requires state agencies to counsel employees with performance deficiencies prior to any extension of their working test period. Agencies must document prior employee counseling and performance evaluations.

Condition: The department did not adequately document the counseling of 4 employees with performance deficiencies whose working test periods were extended. There were no performance evaluations on file for 3 employees and no evidence that the department counseled 3 employees prior to their extensions.

Context: During the audited period, the department extended 77 employees' working test periods. We selected 10 employees for review. Six of the 10 employees had their working test periods extended due to performance deficiencies.

Effect: Extensions of working test periods may not be justified and employee job performance may not improve.

Cause: This appears to be the result of an oversight by management.

Prior Audit Finding: This finding has not been previously reported.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that working test periods are extended in accordance with the Department of Administrative Services' General Letter No. 31. (See Recommendation 9.)

Agency Response: "Effective immediately, all extensions of working test periods packets are reviewed and approved by the Human Resources Administrator or designee."

Weaknesses in Purchasing Card Processing

Criteria: The department's purchasing card policy requires purchases to be pre-approved and supported by all relevant documents. If goods or services are to be delivered to another location, the person receiving the order must verify the order by signing the packing slip or receipt.

Condition: Our review of purchasing cards identified the following conditions:

- There was no prior approval on file to support 48 transactions, totaling $20,348.
- There was inadequate documentation on file to support 6 transactions, totaling $2,467.
- There was no certification that goods and services were properly received for 41 transactions, totaling $20,263.

Context: During the audited period, there were 75 purchasing cards with expenditures totaling $5,424,622. We selected 10 purchasing cards with 114 transactions totaling $30,168. The purchasing cards were selected from Connecticut Valley Hospital, Connecticut Mental Health Center, and Southwest Connecticut Mental Health System.

Effect: There is an increased risk for erroneous, improper, and unauthorized purchases.

Cause: These conditions appear to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over purchasing cards to ensure compliance with established policies and procedures. (See Recommendation 10.)

Agency Response: "Connecticut Valley Hospital: With respect to prior approval and inadequate documentation, during fiscal years 2019 and 2020 all purchasing card holders were reeducated on purchasing card policies and requirements for prior approval along with providing adequate documentation.

All new staff with purchasing card privileges must now be familiar with the purchasing card policy prior to use. A sales receipt and/or packing slip, invoice, and other documentation showing receipt of goods is

submitted to the Fiscal Department prior to the month-end close, which includes the purchasing card reconciliation process.

Connecticut Mental Health Center: CMHC will ensure that purchasing card transactions are properly approved before purchases are made."

Southwest Connecticut Mental Health System: In order to limit the risk of unauthorized purchases, SWCMHS has reduced the number of purchasing cards available for usage. Management has increased its oversight where purchases are now being reviewed by both a Fiscal Officer and Manager."

Weaknesses in the Processing of Contracts

Criteria: The Office of Policy and Management (OPM) has created various forms (i.e. affidavits, affirmations, certifications) to assist state agencies in complying with statutory contracting requirements. Contractors must include some of the forms when they submit proposals to an agency and others when the contract is executed.

In accordance with the OPM Procurement Standards for Personal Services Agreements and Purchase of Service Contracts, contractors must not begin work until a contract is fully executed.

The procurement standards also require state agencies to submit a written contractor performance evaluation within 60 days of the completion of work.

Condition: Our review of contracts identified the following conditions:

- Required affidavits, affirmations, and certifications were not on file for 5 contracts, totaling $13,110,799.
- Contracts were signed between 26 and 179 days after the start of the contract period for 6 contracts, totaling $5,191,796. For one of the contracts, DMHAS paid $43,845 for services prior to execution.
- DMHAS did not prepare contractor evaluations for 7 contracts, totaling $10,448,920. Upon further inquiry, the department informed us that it did not complete contractor evaluations for any contracts that expired during the audited period.

Context: During the audited period, there were 507 contracts, totaling $1,165,975,068. We selected 25 contracts, totaling $27,400,154, for review.

Effect: There is an increased risk of financial losses and the state contracting with entities that failed to perform.

Cause: These conditions appear to be the result of a lack of oversight by management and staffing shortages.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over contract processing to ensure compliance with purchasing laws and regulations. (See Recommendation 11.)

Agency Response: "The Contract Unit will prepare an instructional document for all Program Managers to use when completing the contract evaluation form as required within 60 days of the end of the contract. In addition, training will be provided to appropriate Program Managers, for completion of the evaluation form, before June 30, 2020."

Weaknesses in Provider Monitoring

Background: The department contracts with a network of private nonprofit providers for a variety of mental health and addiction services. There are 19 DMHAS units responsible for program monitoring. The monitoring units ensure that providers properly deliver services and meet established standards of care. This is accomplished by meeting with providers, conducting site visits, reviewing program goals, and other methods. The Fiscal and Internal Audit divisions are responsible for fiscal monitoring. Through reviews of financial and audit reports, the divisions ensure that providers use funds properly and return unexpended funds. .

Criteria: The department's human services contracts require that DMHAS annually review and evaluate the performance of each provider through examinations of documents and reports and/or site visits to funded facilities. Sound business practice provides that agencies should have formal monitoring procedures in place and should adequately document their monitoring efforts.

Additionally, the department's human services contracts require providers to submit 8-month interim reports no later than March 31st and annual financial reports no later than September 30th. Providers must submit a complete annual financial audit within 6 months after the

close of the provider's fiscal year. The Internal Audit Division must review the audit reports and perform a reconciliation to determine whether providers have any unexpended funds. Such reviews are to be completed within 6 months from the date the audit reports are received.

Condition:

Our review of the 19 units' monitoring practices revealed that 15 did not have formal monitoring procedures. In addition, the units did not consistently document their monitoring efforts (e.g., meeting minutes, site visit reports, and program goal reviews). The 15 units were responsible for 560 programs, with $351,155,905 in funding during the audited period.

Our review of the monitoring activities performed during the fiscal year ended June 30, 2018 for 20 programs administered by 16 providers identified the following conditions:

- Two providers, with $21,063,380 in funding, submitted their 8-month interim reports 20 and 46 days late for the fiscal year ended June 30, 2018.

- Five providers, with $43,489,509 in funding, submitted their annual financial reports between 22 and 37 days late for the fiscal year ended June 30, 2018.

- There was no evidence that DMHAS monitored one provider's program. The provider received $943,323 for the fiscal year ended June 30, 2018.

- DMHAS did not review 6 providers' audit reports. The providers received $44,850,580 in funding for the fiscal year ended June 30, 2018.

- DMHAS reviewed 3 providers' audit reports between 6 and 78 days late. The providers received $23,387,066 in funding for the fiscal year ended June 30, 2018.

Context:

During the audited period, there were 846 programs administered by 147 providers. Funding for the programs totaled $233,027,881 and $274,250,081 for the fiscal years ended June 30, 2017 and 2018, respectively. We selected 20 programs administered by 16 providers, with funding totaling $12,182,481 for the fiscal year ended June 30, 2018.

Effect:

The lack of monitoring procedures reduces assurance that providers are adequately delivering contracted services and meeting established standards of care.

Failure to promptly obtain and review financial and audit reports increases the risk for the improper use of funds. There is also an increased risk that unexpended funds will not be returned to the department.

Cause: These conditions appear to be the result of staffing shortages, the nature and structure of the department, and lack of management oversight.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over its monitoring of private providers. The department should ensure that it has formal procedures in place and document its monitoring efforts. (See Recommendation 12.)

Agency Response: "The department's Internal Audit Division continues to review the backlog of audit reports for fiscal years 2015 to 2018. Once the backlog is resolved, reports for fiscal year 2019 and forward will be reviewed timely.

DMHAS sends reminders to its private non-profit providers informing them of due dates for all reports. In addition, the department is undergoing technical issues with Core-CT in regards to submission of provider reports through Core-CT. The department is consulting with the Comptroller's Office to resolve these issues.

Commencing in January 2020, monitoring protocols will involve initiating bi-monthly meetings with the SWCMHS Contract Monitoring Unit, program personnel, and lead residential staff. Three of the 6 annual meetings will occur on-site at the Crisis Respite Program and will involve chart and documentation review coupled with formalized agendas."

Inadequate Description of Services in Young Adult Services Contracts

Criteria: Sound business practice provides that contracts should adequately identify the specific services to be provided by contractors.

Condition: The contracts for the Young Adult Services (YAS) program do not adequately describe the contractor's scope of services.

Context: During the audited period, DMHAS paid $99,106,401 to YAS program contractors.

Effect: There is an increased risk that contractors are not providing the intended services.

Cause: This appears to be an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last audit report covering the fiscal years ended June 30, 2015 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should ensure that contracts adequately document the services to be provided by contractors. (See Recommendation 13.)

Agency Response: "The Young Adult Services Division is collaborating with the DMHAS Contract Unit to further clarify the type of programs and funding levels for each service in all new and existing contracts."

Failure to Require Service Organization Control Reports

Background: The department contracted with Advanced Behavioral Health (ABH) to administer the Behavioral Health Recovery Program. Due to the nature of the transactions, the ABH controls are relevant to the department's internal controls over financial reporting.

Criteria: Management is responsible for implementing and maintaining effective internal controls over financial reporting, whether the reporting is processed by the department or outsourced to a service organization.

In accordance with AU-C Section 402, the agreement between the user entity and the service organization should indicate whether the service organization will provide a Service Organization Controls (SOC) report and, if so, whether such a report will be a type 1 or type 2 report. The SOC report is intended to meet the needs of user organizations that require assurance about the controls at a service organization that affect the security, availability, and processing integrity of the systems the service organization uses to process user data and the confidentiality and privacy of the information processed by these systems.

Condition: The department's ABH contract does not require ABH to provide an SOC report.

Context: During the audited period, ABH processed $79,873,660 on behalf of the department for the Behavioral Health Recovery Program.

Effect: Failure to require SOC reports may prevent the department from adequately addressing deficiencies in the design and operating effectiveness of service organizations' information systems.

Cause: This condition appears to be an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 2 audit reports covering the fiscal years ended June 30, 2013 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should require service organizations responsible for significant financial applications and processes to provide appropriate Service Organization Controls reports. (See Recommendation 14.)

Agency Response: "For the Service Organization Control Report (SOC), the department will determine the funding needed and, if within allowable appropriations, will request the contractor to undertake this review."

Failure to Address Information Technology Security Risks

Background: Under the federal Health Insurance Portability and Accountability Act (HIPAA), DMHAS contracted with an independent consultant to perform an objective security risk assessment of the department's internal controls. Areas reviewed included security over networks, the physical information technology environment, HIPPA policies and procedures, and other related best practices. On July 27, 2016, the consultant issued a report of findings, which identified 20 items of varying risk that required corrective action.

Criteria: Sound internal controls dictate that agencies should promptly mitigate and remediate identified information system threats and vulnerabilities.

Condition: Our review of the report's 20 risk items disclosed that DMHAS has not mitigated the risk for 9 items. We would note that 5 of these items were under the purview of other state agencies.

Effect: Failure to address identified threats and vulnerabilities increases the risk for the loss, theft, and inappropriate use of sensitive data.

Cause: A lack of funding and staffing shortages have hindered the department's efforts to mitigate and remedy the identified risk items.

Prior Audit Finding: This finding has been previously reported in the last audit report covering the fiscal years ended June 30, 2015 through 2016.

Recommendation: The Department of Mental Health and Addiction Services and other responsible agencies should promptly mitigate and remediate information system threats and vulnerabilities identified in the July 2016 consultant's report. (See Recommendation 15.)

Agency Response: "As stated in the "Condition" paragraph above, 5 of the 9 items will continue to be outside of the department's ability to resolve them as it is mandated by another state agency to remediate the issues noted. The remaining 4 items to be mitigated is contingent upon available funding and personnel resources."

Weaknesses in the Administration of General Fund Petty Cash

Background: The department operates therapeutic work programs for clients. Client payroll is processed through petty cash accounts and reimbursed by the General Fund.

Criteria: Department procedures require that client work hours are supported by approved timesheets.

Condition: Our review of petty cash disbursements identified the following conditions:

- Timesheets were not on file to support 2 client payroll disbursements totaling $98.
- Timesheets did not support 5.25 hours ($48) for 3 client payroll disbursements totaling $133.

Context: During the audited period, the department maintained 7 General Fund petty cash accounts. Disbursements from the accounts totaled $436,755. We reviewed 20 disbursements, totaling $2,420, made from the General Fund petty cash account maintained by Connecticut Valley Hospital. Of the 20 disbursements selected, 10 disbursements totaling $412 were for client payroll.

Effect: There is an increased risk that the department paid clients for time they did not work.

Cause: During the audited period, supervisors submitted client timesheets to the Vocational Rehabilitation Department. Vocational Rehabilitation then prepared a weekly summary sheet that it sent to fiscal staff for processing. Fiscal staff realized there were discrepancies between the timesheets and weekly summary sheets and began reconciling past timesheets to payments. However, due to limited staffing, fiscal staff

did not complete their reconciliations during our review. We note that the Connecticut Valley Hospital has since changed its procedures. The Vocational Rehabilitation Department now forwards weekly summary sheets and timesheets to fiscal staff for processing.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over petty cash funds to ensure compliance with policies and procedures. (See Recommendation 16.)

Agency Response: "During fiscal year 2019, CVH conducted a review of fiscal year 2017 and fiscal year 2018 timesheets and subsequently strengthened procedures over processing client payroll. During this review, all records were corrected to reflect hours worked.

Since that time, CVH's Business Office has since taken over responsibility of the timesheet review, which includes a process that enables them to process clients' timesheets timely and accurately. The Business Office receives timesheets along with the payroll summary about 1 week prior to the end of the payroll period. If a timesheet has a discrepancy, office staff work with the hospital's Vocational Program staff to make necessary corrections prior to the end of the pay period."

Weaknesses in the Administration of Trustee Funds

Background: The department maintains trustee accounts at each of its facilities. Trustee funds are utilized for general client support, enrichment activities, worker programs, loans, and other purposes.

Criteria: In accordance with Section IV.C.4 of the Accounting Procedures Manual for Trustee Accounts, all payments for goods and services should be supported by a purchase order and substantiated by vendor invoices and receipts. Any single expenditure in excess of $1,000 must receive prior approval from the State Comptroller.

Sound business practice provides that documentation should be maintained to support that the intended clients received gift cards, cash, and checks.

Condition: Our review of trustee account disbursements identified the following exceptions:

- Purchase orders for 20 disbursements, totaling $4,758, were not on file or not properly approved.
- The department did not obtain prior State Comptroller approval for 7 expenditures in excess of $1,000, totaling $9,374.
- Supporting documentation was missing or inadequate for 13 disbursements, totaling $7,560.
- There was no evidence that the intended clients received gift cards, cash, and checks for 7 disbursements, totaling $4,560.

Context: During the audited period, the department maintained 11 trustee accounts. Disbursements from the accounts totaled $1,607,706. We selected 50 disbursements, totaling $21,072, from 7 trustee accounts maintained by Connecticut Valley Hospital, River Valley Services, Western Connecticut Mental Health Network, Connecticut Mental Health Center, and Southwest Connecticut Mental Health System.

Effect: There is an increased risk for the loss and misuse of trustee funds.

Cause: These conditions appear to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 3 audits covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over trustee accounts to ensure compliance with established policies and procedures. (See Recommendation 17.)

Agency Response: "Connecticut Valley Hospital / River Valley Services: All policies and procedures related to trustee funds including gift cards, Comptroller approval for transactions in excess of $1,000, and purchasing requirements were updated. In addition, staff of the Connecticut Valley Hospital (CVH) and River Valley Services (RVS) were reeducated on aligning transaction practices with current policies and procedures.

In addition, the CVH Trustee Fund no longer purchases gift cards for program purposes and RVS discontinued use of purchasing gift cards for clients.

Western Connecticut Mental Health Network: The Fiscal Office will authorize written approval and all copies will be filed accordingly by office staff.

Effective immediately, appropriate documentation will be submitted to the Comptroller's Office for approval before submitting a request to use the trustee account. In addition, DMHAS policies will be updated by February 1, 2020 to include language to state that any expenditures or client loans over $1,000 will first need approval from the Comptroller's Office.

WCMHN does not utilize gift cards at this time. Advanced Behavioral Health is currently providing money management for the WCMHN clients. Policies and procedures outlining the process for documenting receipt of cash and checks will be complete by February 15, 2020.

Connecticut Mental Health Center: CMHC will ensure going forward that clients' timesheets are dated by their supervisor. The CMHC Business Office will now add a date near the signature line to support petty cash fund disbursements. For gift cards, CMHC has created a procedure for the disbursements in question. Gift Card disbursements are now supported by documentation that corresponds to a CMHC client.

Southwest Connecticut Mental Health System: Internal controls have now been strengthened to ensure that: 1) single expenditures in excess of $1,000 are approved by the State Comptroller, and 2) business procedures and practices have been strengthened to ensure compliance with accounting procedures noted in the Trustee Accounting Manual."

Weaknesses in the Administration of Client Loans

Background: The Southwest Connecticut Mental Health System (SWCMHS) trustee account may be used for loans to clients for basic living expenses, such as food, lodging, travel, clothing, and personal hygiene supplies.

Criteria: The SWCMHS operational manual for trustee accounts requires that requests for loans be approved by a designated signer before payments are processed. Additionally, Section IV.C.5. of the Accounting Procedures Manual for Trustee Accounts requires prior approval from the State Comptroller for loans exceeding $1,000.

Sound business practice provides that efforts should be made to collect loan repayments. In the event that an agency finds a loan is uncollectible, it should be written off in accordance with Section 3-7 of the General Statutes.

Condition: Our review of client loans made from the SWCMHS trustee account identified the following conditions:

- Approvals were not dated for 3 loans totaling $2,485. Therefore, we could not verify that the loans were approved prior to payment.
- Prior approval was not obtained from the State Comptroller for 5 loans totaling $8,155.
- There was no evidence that the department attempted to collect 6 loans, totaling $7,945, after more than 6 months of delinquency.
- As of February 28, 2019, there were 56 outstanding client loans totaling $33,208. Of the 56 loans, 34 loans totaling $14,860, have been inactive for more than one year. The department did not write off any uncollectible loan.

Context: During the audited period, the SWCMHS trustee account made 42 client loans, totaling $24,116. We selected 10 client loans totaling $11,010.

Effect: There is an increased risk of improper client loans, or that clients may not repay their loans. In addition, DMHAS may not accurately value trustee account balances due to the inclusion of uncollectible loans.

Cause: These conditions appear to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last audit report covering the fiscal years ended June 30, 2015 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that client loans are properly administered. (See Recommendation 18.)

Agency Response: "The client loan process is now being closely monitored to ensure that loan requests are closely reviewed for approval by both a Fiscal Officer and Manager. Client names are reconciled with the Clients Funds, which is managed by ABH, for possible repayments."

Weaknesses in the Administration of Client Funds Managed by DMHAS

Background Clients who are unable to manage their finances may be voluntarily or involuntarily enrolled in a money management program. For clients receiving Social Security benefits, DMHAS may be appointed as representative payee.

Criteria: Department procedures require the development of budgets signed by clients and money management program staff. Payments made on behalf of clients should be supported by receipts.

Sound business practice provides that documentation should be maintained to support that clients received cash and checks.

Condition: Our review of client fund disbursements identified the following exceptions:

- Client budgets were missing, not updated, or not properly signed for 26 disbursements totaling $6,305.
- Supporting receipts for 12 disbursements were missing totaling $4,660.
- There was no evidence that clients received cash and checks for 5 disbursements totaling $360.

Context: During the audited period, the department maintained 8 client fund accounts. Disbursements from the accounts totaled $4,986,952. We selected 40 disbursements, totaling $8,008, from 5 client fund accounts maintained by Connecticut Valley Hospital, River Valley Services, Western Connecticut Mental Health Network, and Connecticut Mental Health Center.

Effect: There is an increased risk for the loss and misuse of client funds.

Cause: These conditions appear to be the result of an oversight by management.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over client funds to ensure compliance with established policies and procedures. (See Recommendation 19.)

Agency Response: "Connecticut Valley Hospital: Regarding missing evidence of clients' receipt of funds, if a Mental Health Assistant withdraws funds on behalf of a client at the Valley Finance window, staff ask for a signed receipt to be returned within 5 days. Valley Finance tracks compliance with this process and reports to its Governing Body committee on a monthly basis.

River Valley Services: Effective May 2018, River Valley Services contracted with a not-for-profit entity, Advanced Behavioral Health,

Inc. to manage client funds in accordance with the requirements of the Social Security Administration.

ABH has developed a Policy and Procedure Manual related to its fiduciary relationship with River Valley Services in the operations of the Client Money Management Program. This includes policies and procedures to properly budget, document, and manage all transactions including cash receipts, check disbursements, and purchase requisitions.

Additionally, the program provides adequate resources to ensure separation of duties and compliance with internal control processes related to the Client Money Management Program.

Western Connecticut Mental Health Network: In fiscal year 2020, ABH assigned a money manager who is embedded on site at the WCMHN to coordinate money management issues with staff and clients. Case managers review and submit client budgets monthly into a database. The database will not generate payments without an updated budget. Paper copies signed by clients are filed and audited annually by the WCMHN Fiscal Department.

This finding was prior to utilizing an online processing system. The system will not generate a payment without proper documentation attached. The money manager will not accept incomplete requests that do not have invoices attached. Case managers complete the form, attach the appropriate invoices, and then submit for approval into the online system. Once done, this program prompts the supervisor to approve the request and ABH processes the request within 24 to 48 hours. Furthermore, ABH Money Management utilizes a signature log for money management disbursements in which the clients have to sign for their funds.

Connecticut Mental Health Center: CMHC will work towards ensuring that the clients' budgets are current, signed, and in place before disbursements are made."

Failure to Return Inactive Client Funds to Rightful Owners

Background: In 2013, the department contracted with a private nonprofit entity to provide client money management services for Southwest Connecticut Mental Health System (SWCMHS). At that time, the department opened a new account and transferred active client balances to this account. The department left inactive client balances in their original account.

Criteria: In accordance with Section IV of the State Comptroller's Accounting Procedures Manual for Trustee Accounts, when an individual has left a facility and has client funds, agencies must make every effort to return the funds to the rightful owner. When all attempts to return the funds are exhausted, then the funds are deemed unclaimed. Agencies must hold the unclaimed funds for 3 years before reporting them to the Office of the State Treasurer.

Condition: Since 2013, $48,825 in client funds have remained inactive in 2 SWCMHS bank accounts. The department has not attempted to return the funds to the rightful owners or escheat them to the Office of the State Treasurer.

Effect: Unclaimed funds have not been returned to the rightful owners.

Cause: The department has not been able to determine individual client balances due to recordkeeping issues and missing files.

Prior Audit Finding: This finding has been previously reported in the last audit report covering the fiscal years ended June 30, 2015 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should make every effort to return unspent client funds to the rightful owners and escheat unclaimed funds to the Office of the State Treasurer. (See Recommendation 20.)

Agency Response: "For clients whose funds cannot be returned directly to them, SWCMHS is currently working with the State Treasurer's Office for submission of funds to its Unclaimed Property Division. Estimated completion is scheduled for the end of fiscal year 2020."

Weaknesses in the Administration of Young Adult Services Client Support Funds

Background: To support the successful transition of youth to adulthood, the Young Adult Services (YAS) Unit offers client support funds to clients based on clinical and financial needs. YAS client support funds are administered by private providers and state-operated local mental health authorities (LMHA). While private providers administer client support funds themselves, state-operated LMHA contract with fiduciaries to administer client support funds.

Criteria: Department procedures require clients to complete applications and submit documentation regarding their income, assets, and savings. Based on this information, the department identifies appropriate supports and prepares client budgets. Expenses not included in the

budget must be requested and approved in advance. Disbursements of $500 or more require two approving signatures. Disbursements should be supported by adequate documentation, including receipts. Group activities also must be supported by an attendance sheet that identifies all clients and staff who participated. Unexpended funds must be promptly returned.

Condition: Our review of client support fund disbursements identified the following conditions:

- Applications were missing for 29 disbursements totaling $16,078.
- Client budgets were missing for 21 disbursements totaling $11,859.
- Requests were missing or not properly approved for 14 disbursements totaling $11,396.
- Supporting receipts and rental agreements were missing or inadequate for 7 disbursements totaling $5,485.
- The attendance sheet for a group activity was missing for one $957 disbursement.
- For 2 disbursements, $344 in unexpended funds were returned 88 and 200 days after disbursement.

Context: During the audited period, there were 8 contractors administering YAS client support funds on behalf of state-operated LMHAs. Such contractors disbursed a total of $3,210,820 in client support funds during the 2-year period. We selected 40 disbursements, totaling $22,077, processed on behalf of River Valley Services, Connecticut Mental Health Center, Capitol Region Mental Health Center, and Southwest Connecticut Mental Health System.

Effect: There is an increased risk for the loss and misuse of Young Adult Services client support funds.

Cause: The local mental health authorities and fiduciary agencies are unsure which is responsible for maintaining certain documentation.

Prior Audit Finding: This finding has been previously reported in the last 3 audit reports covering the fiscal years ended June 30, 2011 through 2016.

Recommendation: The Department of Mental Health and Addiction Services should strengthen internal controls over Young Adult Services client support

funds to ensure compliance with established policies and procedures. (See Recommendation 21.)

Agency Response: "In response to the findings, it was determined that many of the documentation (applications, budgets, and approvals) that the fiduciary agencies were unable to provide to the auditors were located at the state-operated LMHAs. As a result of these instances, in which the fiduciary agency staff appeared unaware of the documentation maintained by the LMHA, OOC YAS leadership has requested from programs and the auditors that the YAS Director of Operations or designee and YAS leadership from the identified LMHAs are contacted to participate in the audit process along with the fiduciary agency going forward.

OOC YAS leadership has modified the existing YAS guidelines to address the following findings: 1) expenditures equal to or over $500 can be approved by hand signature, electronic signature, or by email confirmation; 2) clients who are eligible to participate in group activities or to receive incentives or who are accessing funds for one time or emergency requests are not required to have an application or budget completed unless they request and receive ongoing funding to support their individual needs and recovery goals; and 3) although every effort will be made to secure physical receipts, this may not be possible, at times, given the functioning level of the clients with whom we work. Therefore, the approved process for the client's acknowledgment of the receipt of funds is deemed sufficient.

DMHAS YAS managers will increase the frequency of audits, particularly at those agencies for which findings have been identified. Follow up audits by OOC YAS managers in collaboration with the YAS Director of Operations will occur for those agencies that require corrective action to rectify these audit findings."

Auditors' Concluding Comments: We notified the YAS Director of Operations, YAS leadership, and fiduciary agency staff of all requested documentation. Additionally, we notified the YAS Director of Operations of all missing documentation prior to concluding our review.

Unnecessary Utility Expenditures

Criteria: Sound internal controls dictate that local mental health authorities should promptly inform the Department of Mental Health and Addiction Services of any location changes.

Condition: The Franklin S. Dubois Center in Stamford relocated in August 2018. The department paid the electric bills for the prior location for 8 months

after the move. The department paid $37,728 for the center's electric bills and did not recoup any of the funds.

Effect: The department incurred unnecessary expenditures.

Cause: There was a lack of communication between facility and fiscal staff.

Prior Audit Finding: This finding has not been previously reported.

Recommendation: The Department of Mental Health and Addiction Services should institute procedures to ensure that local mental health authorities promptly notify all appropriate parties of location changes. (See Recommendation 22.)

Agency Response: "The Plant Facility Manager has put in place a plan to ensure that all vendors, for each facility, are contacted upon relocation. The plan includes a checklist of all vendors at each facility with contact information to ensure that accounts/services are properly disconnected, when needed."

Lack of an Overtime Process for Timekeepers at Whiting Forensic Hospital

Background: There were two timekeepers at Whiting Forensic Hospital during the audited period. The timekeepers' duties include maintaining appropriate staffing levels, entering time and attendance data, obtaining timesheet signatures, and managing employee leave requests.

Criteria: The department's timekeeping policy requires all overtime to be approved in advance. Each request to work overtime must include the number of hours requested and a justification for the extra hours.

Collective bargaining agreements require the department to equally distribute overtime among qualified volunteers with similar skills and duties.

Condition: During 2018, one of the timekeepers worked 2,307 overtime hours and earned $131,259 in overtime wages. The other worked 312 overtime hours and earned $20,114 in overtime wages.

Our review of the timekeepers' overtime revealed that Whiting Forensic Hospital does not have a process in place to document timekeeper overtime requests, approvals, and equalization efforts. Therefore, there is no evidence that any of the 2,619 timekeepers' 2018 overtime hours were properly requested, approved, and justified. Additionally, there is

no evidence that the department attempted to equally distribute the overtime between the timekeepers.

Effect: The lack of documented overtime requests, approvals, and equalization efforts increases the risk for timekeepers to abuse overtime and incur unnecessary costs.

Cause: The timekeepers' supervisor informed us that she verbally approves overtime. The lack of a documented overtime process appears to be an oversight by management.

The timekeepers work a significant amount of overtime because they are the only employees in that role, and there is no coverage for the third shift.

Prior Audit Finding: This finding has not been previously reported.

Recommendation: The Department of Mental Health and Addiction Services should create a system to document timekeeper overtime requests, approvals, and equalization efforts. (See Recommendation 23.)

Agency Response: "Effective December 2019, WFH introduced a pre-booking process for timekeepers, similar to the process for pre-booking Nurse Supervisors, which enables them to sign up for overtime 1-week in advance.

As previously mentioned, DMHAS will introduce a new system at WFH, which will automate all timekeeping. With this system, WFH will be able to eliminate all overtime for timekeepers, as the automated system will account for holidays, weekends, and time currently filled by overtime. In addition, WFH will not require the hiring of any additional timekeeping staff with the new system in place."

RECOMMENDATIONS

Status of Prior Audit Recommendations

Our prior audit report on the Department of Mental Health and Addiction Services contained 18 recommendations. Four have been implemented or otherwise resolved and 14 have been repeated or restated with modifications during the current audit.

- The Department of Mental Health and Addiction Services should promptly follow up with providers when concerns are raised and exercise its contractual rights to withhold payments when necessary. **The department has taken corrective action to address the questioned costs incurred by a provider. The recommendation will not be repeated.**

- The Department of Mental Health and Addiction Services should strengthen internal controls over the processing of contracts. Those controls should ensure that the department follows all contracting statutes, regulations, and policies. **We continued to note weaknesses in the processing of contracts. The recommendation will be modified and repeated. (See Recommendation 11.)**

- The Department of Mental Health and Addiction Services should strengthen internal controls over its monitoring of private providers. Monitoring could include the use of data, reports, and site visits. **We continued to note weaknesses in the monitoring of providers. The recommendation will be modified and repeated. (See Recommendation 12.)**

- The Department of Mental Health and Addiction Services Young Adult Services unit should strengthen internal controls over the Client Support Fund program. **While corrective action was taken to address the internal control deficiencies, we continued to note deficiencies related to client support fund disbursements. The recommendation will be modified and repeated. (See Recommendation 21.)**

- The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that contracts adequately represent services provided by contractors. **We continued to note inadequate descriptions of services in Young Adult Services contracts. The recommendation will be modified and repeated. (See Recommendation 13.)**

- The Department of Mental Health and Addiction Services should promptly notify affected clients of potential losses, escheat abandoned funds to the State Treasurer, and ensure that contractors fulfill agreed-upon requirements and return unexpended funds. **While corrective action was taken to address the monitoring of a client fund money management contractor, we continued to note inactive client funds that were not returned or escheated in a timely manner. The recommendation will be modified and repeated. (See Recommendation 20.)**

- The Department of Mental Health and Addiction Services should develop standardized, agency-wide procedures to ensure adequate controls over client funds. **We continued to note deficiencies related to client fund disbursements. The recommendation will be modified and repeated. (See Recommendation 19.)**

- The Department of Mental Health and Addiction Services should strengthen internal controls to ensure compliance with Social Security Administration requirements and revise internal policies to ensure the safeguarding of client funds. **Corrective action was taken to address internal control deficiencies over state-operated client funds. The recommendation will not be repeated.**

- The Department of Mental Health and Addiction Services should establish policies for the monitoring of private providers contracted to perform fiscal functions, and establish formal procedures for providers to report concerns. **Corrective action was taken to address the internal control deficiencies over contracted client funds. The recommendation will not be repeated.**

- The Department of Mental Health and Addiction Services should implement procedures to ensure that inactive client accounts are promptly closed. The department should escheat excess funds to the State Treasurer as required. **We continued to note inactive client funds that were not returned or escheated in a timely manner. The recommendation will be modified and repeated. (See Recommendation 20.)**

- The Department of Mental Health and Addiction Services should develop standardized, agency-wide procedures to ensure adequate controls over trustee funds. **We continued to note weaknesses in the administration of trustee funds and client loans. The recommendation will be modified and repeated as 2 separate recommendations. (See Recommendations 17 and 18.)**

- The Department of Mental Health and Addiction Services should strengthen internal controls over purchasing cards to ensure that cardholders adhere to the state's cardholder policy. **We continued to note weaknesses in the processing of purchasing cards. The recommendation will be modified and repeated. (See Recommendation 10.)**

- The Department of Mental Health and Addiction Services should promptly address weaknesses in information technology controls. The department should ensure that contracts require service organizations to obtain a Service Organization Control (SOC) report when appropriate. **We continued to note concerns regarding Service Organization Control reports and information technology security risks. The recommendation will be modified and repeated as 2 separate recommendations. (See Recommendations 14 and 15.)**

- The Department of Mental Health and Addiction Services should establish policies and procedures for adequate recording of time worked by employees. The department should improve its monitoring of excessive work hours and overtime costs. **While we noted improvements in the administration of on-call shifts, we continued to note weaknesses**

related to the documenting, approving, and monitoring of overtime worked. The recommendation will be modified and repeated. (See Recommendation 6.)

- The Department of Mental Health and Addiction Services should strengthen controls related to compensatory time and the use of proper time reporting codes. **We continued to note weaknesses related to compensatory time, leave in lieu of accrual, and holiday coding. The recommendation will be modified and repeated as 3 separate recommendations. (See Recommendations 1, 5, and 7.)**

- The Department of Mental Health and Addiction Services should improve oversight of its personnel procedures and practices in areas of paid administrative leave, workers' compensation, medical leave time reporting, and termination procedures. **We continued to note weaknesses related to paid administrative leave, workers' compensation, medical leave, and separation procedures. The recommendation will be modified and repeated as 4 separate recommendations. (See Recommendations 2, 3, 4, and 8.)**

- The Department of Mental Health and Addiction Services should take appropriate action to escheat unclaimed funds of the Behavioral Health Recovery Program in accordance with Section 3-63a of the General Statutes. **Corrective action was taken to address the outstanding checks in the Behavioral Health Recovery Program account. The recommendation will not be repeated.**

- The Department of Mental Health and Addiction Services should improve controls over petty cash funds and ensure compliance with internal and State Comptroller procedures. **We continued to note weaknesses in the administration of General Fund petty cash. The recommendation will be modified and repeated. (See Recommendation 16.)**

Current Audit Recommendations

1. **The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that compensatory time is properly approved and documented.**

   Comment:

   Our review of 10 employees' compensatory time revealed that supervisors did not adequately document approval of 53 hours for 2 employees' compensatory time and did not promptly approve 6 employees' compensatory time.

2. **The Department of Mental Health and Addiction Services should establish procedures to ensure the employee separation process is completed and adequately documented.**

   Comment:

   The department had no documentation on file indicating that it completed the separation process for the 10 terminated employees we reviewed.

3. **The Department of Mental Health and Addiction Services should strengthen internal controls to ensure workers' compensation claims are supported and accurately recorded.**

   Comment:

   Our review of 10 workers' compensation claims revealed that one claim was missing required forms and 4 claims had inaccurately recorded information, resulting in DMHAS underpaying 3 employees by $846.

4. **The Department of Mental Health and Addiction Services should strengthen internal controls to ensure medical leave is administered in accordance with collective bargaining agreements and Family and Medical Leave Act guidelines.**

   Comment:

   Our review of 10 medical leaves revealed that 6 were missing required forms or were inadequate. The department did not promptly complete FMLA documentation for 2 leaves.

5. **The Department of Mental Health and Addiction Services should strengthen internal controls to ensure holiday time is accurately recorded.**

   Comment:

   Our review of holiday time recorded on non-holidays revealed that 9 of 10 employees incorrectly recorded 76 hours of holiday time.

6. **The Department of Mental Health and Addiction Services should strengthen internal controls for overtime to ensure compliance with policies and procedures. The department should adequately track and monitor overtime.**

   Comment:

   Our review of 20 employees' overtime revealed that the department did not document 77.25 overtime hours for 7 employees, overtime was not properly requested and approved for 5 employees, and overtime equalization efforts were not documented for 5 employees. In addition, Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH) did not code overtime to the units the employees actually worked the overtime. Five employees worked more than 30 consecutive days on 30 occasions and 4 of the employees earned more than double their annual salaries during the audited period.

7. **The Department of Mental Health and Addiction Services should ensure that the LILA time reporting code is adjusted in accordance with Core-CT Job Aid procedures.**

   Comment:

   Our review of 10 instances in which DMHAS used the LILA time reporting code revealed that the department did not promptly adjust leave time or collect overpayments in 5 instances and did not take any corrective action in one instance.

8. **The Department of Mental Health and Addiction Services should comply with state personnel regulations and bargaining unit contracts when placing employees on paid administrative leave.**

   Comment:

   Our review of 10 employees on paid administrative leave revealed that the department did not obtain DAS approval to extend all 10 employees' leave for an additional 30 days, and did not obtain OLR approval to extend the leave beyond 60 days for 7 employees. Furthermore, 3 employees were on leave beyond the allowable 60 days.

9. **The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that working test periods are extended in accordance with the Department of Administrative Services' General Letter No. 31.**

   Comment:

   Our review of 10 extended working test periods revealed that the department did not adequately document the counseling of 4 employees with performance deficiencies whose working test periods were extended. There were no performance evaluations on file for 3 employees and no evidence that the department counseled 3 employees prior to their extensions.

10. **The Department of Mental Health and Addiction Services should strengthen internal controls over purchasing cards to ensure compliance with established policies and procedures.**

    Comment:

    Our review of 114 purchasing card transactions revealed that there was no prior approval on file for 48 transactions, there was inadequate documentation for 6 transactions, and there was no certification that the department received goods and services for 41 transactions.

11. **The Department of Mental Health and Addiction Services should strengthen internal controls over contract processing to ensure compliance with purchasing laws and regulations.**

    Comment:

    Our review of 25 contracts revealed that required affidavits, affirmations, and certifications were not on file for 5 contracts. In addition, contracts were signed between 26 and 179 days after the start of the contract period for 6 contracts, and contractor evaluations were not completed for 7 contracts.

12. **The Department of Mental Health and Addiction Services should strengthen internal controls over its monitoring of private providers. The department should ensure that it has formal procedures in place and document its monitoring efforts.**

    Comment:

    Our review of the 19 units' monitoring practices revealed that 15 did not have formal monitoring procedures. In addition, the units did not consistently document their monitoring efforts (e.g., meeting minutes, site visit reports, and program goal reviews). Our review of the department's monitoring of 20 programs administered by 16 providers revealed that 2 providers submitted their 8-month interim reports late, 5 providers submitted their annual financial reports late, and there was no evidence that DMHAS monitored one provider's program. DMHAS did not review 6 providers' audit reports.

13. **The Department of Mental Health and Addiction Services should ensure that contracts adequately document the services to be provided by contractors.**

    Comment:

    Our review revealed that contracts for the Young Adult Services program did not adequately identify the contractor's scope of services.

14. **The Department of Mental Health and Addiction Services should require service organizations responsible for significant financial applications and processes to provide appropriate Service Organization Controls reports.**

    Comment:

    Our review revealed that the department's contract with a service organization responsible for significant financial applications and processes does not require an SOC report to be provided.

15. **The Department of Mental Health and Addiction Services and other responsible agencies should promptly mitigate and remediate information system threats and vulnerabilities identified in the July 2016 consultant's report.**

    Comment:

    Our review disclosed that the department has not taken corrective action to address 9 of 20 items of risk identified in a HIPAA security risk assessment report.

16. **The Department of Mental Health and Addiction Services should strengthen internal controls over petty cash funds to ensure compliance with policies and procedures.**

    Comment:

    Our review of 20 petty cash disbursements revealed that documentation was not on file for 2 disbursements and did not support $48 paid for 3 disbursements.

17. **The Department of Mental Health and Addiction Services should strengthen internal controls over trustee accounts to ensure compliance with established policies and procedures.**

    Comment:

    Our review of 50 trustee account disbursements revealed that purchase orders were not on file or were improperly approved for 20 disbursements, prior State Comptroller approval was not obtained for 7 disbursements over $1,000, and supporting documentation was missing or inadequate for 13 disbursements. In addition, there was no evidence that the intended clients received gift cards, cash, and checks for 7 disbursements.

18. The Department of Mental Health and Addiction Services should strengthen internal controls to ensure that client loans are properly administered.

Comment:

Our review of 10 client loans revealed that 3 loan approvals were not dated, 5 loans in excess of $1,000 did not obtain the State Comptroller's prior approval, and there was no evidence that the department attempted to collect 6 loans with no activity for more than 6 months. In addition, there were 34 loans, totaling $14,860, inactive for more than one year. The department had not written off any uncollectible loans.

19. The Department of Mental Health and Addiction Services should strengthen internal controls over client funds to ensure compliance with established policies and procedures.

Comment:

Our review of 40 client fund disbursements revealed that 26 disbursements' client budgets were missing or inadequate, 12 disbursements' supporting receipts were missing, and there was no evidence that clients received cash and checks for 5 disbursements.

20. The Department of Mental Health and Addiction Services should make every effort to return unspent client funds to the rightful owners and escheat unclaimed funds to the Office of the State Treasurer.

Comment:

Our review revealed that $48,825 in client funds remained inactive in 2 bank accounts since at least 2013. The department has not attempted to return the funds to their rightful owners or escheat them to the Office of the State Treasurer.

21. The Department of Mental Health and Addiction Services should strengthen internal controls over Young Adult Services client support funds to ensure compliance with established policies and procedures.

Comment:

Our review of 40 client support fund disbursements revealed that 29 disbursements' applications and 21 disbursements' client budgets were missing, 14 disbursements' requests were missing or improperly approved, and 7 disbursements' supporting receipts and rental agreements were missing or inadequate. Our review also revealed that one disbursement's group activity attendance sheet was missing, and DMHAS did not promptly return 2 disbursements' unexpended funds.

22. **The Department of Mental Health and Addiction Services should institute procedures to ensure that local mental health authorities promptly notify all appropriate parties of location changes.**

    Comment:

    The Franklin S. Dubois Center in Stamford relocated in August 2018. The department paid the electric bills for the prior location for 8 months after the move. The department paid $37,728 for the center's electric bills and did not recoup any of the funds.

23. **The Department of Mental Health and Addiction Services should create a system to document timekeeper overtime requests, approvals, and equalization efforts.**

    Comment:

    Our review of the timekeepers' overtime revealed that Whiting Forensic Hospital does not have a process in place to document timekeeper overtime requests, approvals, and equalization efforts. Therefore, there is less evidence that any of the 2,619 timekeepers' 2018 overtime hours were properly requested, approved, and justified.

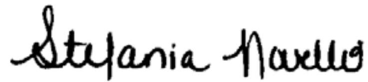
ACKNOWLEDGMENTS

The Auditors of Public Accounts would like to recognize the auditors who contributed to this report:

Xiaofeng Chen
Audrey Kelliher
Nancy Niedzwiecki
Stefania Novello

CONCLUSION

In conclusion, we wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Department of Mental Health and Addiction Services during the course of our examination



Stefania Novello
Principal Auditor

Approved:

John C. Geragosian
State Auditor

Robert J. Kane
State Auditor