BEFORE THE ARIZONA BOARD

OF BEHAVIORAL HEALTH EXAMINERS

In the Matter of: **GARY STRAUS, LCSW-3663,** **Licensed Clinical Social Worker,** **In the State of Arizona.** **RESPONDENT**	**CASE NO. 2012-0127** **CONSENT AGREEMENT**

In the interest of a prompt and speedy settlement of the above captioned matter, consistent with the public interest, statutory requirements and responsibilities of the Arizona State Board of Behavioral Health Examiners ("Board"), and pursuant to A.R.S. §§ 32-3281(H) and 41-1092.07(F)(5), Gary H. Straus ("Respondent") and the Board enter into this Consent Agreement, Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as a final disposition of this matter.

RECITALS

Respondent understands and agrees that:

1. Any record prepared in this matter, all investigative materials prepared or received by the Board concerning the allegations, and all related materials and exhibits may be retained in the Board's file pertaining to this matter.

2. Respondent has the right to a formal administrative hearing at which Respondent can present evidence and cross examine the State's witnesses. Respondent hereby irrevocably waives his right to such formal hearing concerning these allegations and irrevocably waives his right to any rehearing or judicial review relating to the allegations contained in this Consent Agreement.

3. Respondent has the right to consult with an attorney prior to entering into this Consent Agreement.

4. Respondent acknowledges and agrees that upon signing this Consent Agreement and returning it to the Board's Executive Director, Respondent may not revoke his acceptance of this Consent Agreement or make any modifications to it. Any modification of this original document is ineffective and void unless mutually approved by the parties in writing.

5. The findings contained in the Findings of Fact portion of this Consent Agreement are conclusive evidence of the facts stated herein and may be used for purposes of determining sanctions in any future disciplinary matter.

6. This Consent Agreement is subject to the Board's approval, and will be effective only when the Board accepts it. In the event the Board in its discretion does not approve this Consent Agreement, this Consent Agreement is withdrawn and shall be of no evidentiary value, nor shall it be relied upon or introduced in any disciplinary action by any party hereto, except that Respondent agrees that should the Board reject this Consent Agreement and this case proceeds to hearing, Respondent shall assert no claim that the Board was prejudiced by its review and discussion of this document or of any records relating thereto.

7. Respondent understands that once the Board approves and signs this Consent Agreement, it is a public record that may be publicly disseminated as a formal action of the Board, and that it shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

The Board issues the following Findings of Fact, Conclusions of Law and Order:

FINDINGS OF FACT

1. Respondent is the holder of License No. LCSW-3663 for the practice of clinical social work in Arizona.

2. While employed as a behavioral health therapist at a hospital ("Hospital"), Respondent evaluated a client ("Client") from 4:00 – 6:00 am on 06/30/11.

3. At that time, Respondent was aware of the following:

a. Client was psychotic and suicidal and had to be physically restrained.

b. Client was enrolled for ongoing behavioral health services at a behavioral health agency ("Agency 1").

c. The provisional discharge plan when Client was cleared medically was to transfer Client to Agency 1's psychiatric hospital or another behavioral health entity ("Agency 2").

4. At 10:49, a doctor at Hospital ("Doctor") documented the following:

a. Client has an underlying history of severe mental illness, schizophrenia, and PTSD.

b. "[Client] has a history of being from [Agency 1] on a recurrent basis, and has a history of recurrent bath salts snorting."

c. "[Client] is currently somnolent and sedated."

d. "Prior to this, he was having visual and auditory hallucinations, and was a danger to himself or others."

e. "[Client] has bipolar disorder with psychotic features, as well as a history of polysubstance abuse."

f. "I did speak with the nurse at [Agency 1] and once he is medically stable, he will be transferred over to [Agency 1] for continued psychiatric care.

5. At 21:50, Respondent documented the following:

a. Client was not court ordered for treatment.

b. Client was not enrolled with a provider.

c. Client denied any suicidal or homicidal ideation and said he would never use bath salts again.

d. Respondent spoke with Doctor, who said Client was "clear psychiatrically".

e. Doctor advised Respondent that Client was not court ordered for treatment.

6. Respondent's 21:50 note was inappropriate where:

a. A supervisor at Hospital ("Supervisor") indicated that another Hospital therapist ("Therapist") evaluated Client in the ICU at 13:45 and noted that Client was court ordered for treatment.

b. Respondent then documented that Doctor told him that Client was not court ordered for treatment without noting that this information appeared inconsistent with Therapist's note.

c. If Respondent had conflicting information as to whether Client was court ordered for treatment, it was his responsibility to determine whether Client was, in fact, court ordered for treatment.

d. This information could have been easily obtained by calling Agency 1.

e. Given the conflicting information available in Client's records, Respondent's decision to record Doctor's statement that Client was not court ordered for treatment without any apparent attempt to determine the accuracy of this statement was inappropriate.

f. It is impossible to reconcile Respondent's note that Client was not enrolled with a provider with Respondent's 4:25 note and Doctor's 10:49 note, both of which reflect that Client was, in fact, enrolled at Agency 1.

g. Respondent documented at 21:50 that Doctor said Client was "clear psychiatrically".

h. This note appears to directly contradict the provisional discharge plan in Respondent's 4:25 note and Doctor's 10:49 note indicating that Client would be transferred to Agency 1 for continued psychiatric care as soon as Client was medically stable.

7. Respondent's conduct was inappropriate based on the following:

a. There is no documentation in Client's record that supports Respondent's statements that Client was not court ordered to treatment and was not enrolled with Agency 1.

b. As a result of Respondent's evaluation note indicating that Client denied any suicidal or homicidal ideation and was "clear psychiatrically", Client was allowed to leave the hospital against medical advice even though Client presented to the hospital with psychotic and violent behaviors.

c. Respondent did not document any basis for his failure to follow 2 previous provisional discharge plans indicating that Client would be transferred to Agency 1 for continuing care following his release from the hospital.

d. As Supervisor noted:

- It was Respondent's responsibility to investigate Client's behavioral health history.
- It appears Respondent never reviewed Client's records.
- As a result, it appears Respondent was unable to provide accurate information to Doctor regarding Client's mental health history and ongoing treatment at Agency 1.
- As a result of Respondent's conduct, Client was allowed to leave the hospital even though he presented as a risk to himself and others.
- Respondent's conduct was "egregious" as it involved patient care."

8. In 2008 and 2009, Hospital documented performance problems by Respondent regarding an inaccurate discharge, a client complaint, and attendance problems.

9. A 05/28/11 Written Warning addressed a number of significant performance problems, including the following:

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a. Respondent has been asked on multiple occasions to ensure that he writes effective PAT Evaluations.

b. Respondent leaves evaluations and re-assessments that could have been done on his shift for the next shift.

c. On 05/07/11, Respondent was asked to complete an evaluation on a patient who was cleared to leave, but left that evaluation to be completed by the next shift.

d. On 05/18/11, Respondent was asked to complete an evaluation on a patient under observation. Respondent never saw this patient during his shift, even though he only saw 3 patients in the ER all night.

e. On 05/26/11, a patient was ready to be discharged and only needed minor coordination in order to be discharged. Respondent never completed the discharge, which resulted in a delay in care.

f. On 05/28/11, Respondent left two patients for "re-evaluation", one requiring a petition and the other was a clear-cut suicide plan of injecting antifreeze into her neck with a needle. "These patients should have been dispositioned prior to [Respondent] leaving the hospital."

g. Numerous complaints that Respondent has been losing consult requests with the excuse that he didn't get them.

h. Respondent's handoff reports were nearly illegible with incorrect information.

i. When asked to clarify information, Respondent was rude and defensive.

j. Numerous complaints that Respondent was sleeping in the break room.

10. A 07/02/11 termination letter by Supervisor indicated the following:

a. Respondent had ongoing performance issues that he failed to resolve after his 05/38/11 Corrective Action, including the following:

- Issues with handoff reports
- Leaving prior to the end of his shift
- Inaccurate or illegible documentation
- Not clocking in and out for breaks.

b. When Respondent was given his previous written warning on 05/28/11, Respondent indicated, "This is bullshit."

c. On 06/14/11, Respondent received a handoff from his Supervisor.

d. Respondent was given specific instructions by Supervisor regarding the steps that needed to be taken to complete a case.

e. Respondent verbally indicated that he understood the instructions from Supervisor.

f. Respondent failed to complete the required steps in order to obtain authorization for a patient.

g. "These errors damaged our reputation due to the faxing of a blank form and failure to obtain prior authorization."

h. "Moreover, failure to obtain prior authorization cost our hospital a significant amount of money."

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent pursuant to A.R.S. § 32-3251 *et seq.* and the rules promulgated by the Board relating to Respondent's professional practice as a licensed behavioral health professional.

2. The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-3251(12)(k),any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client.

3. The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-3251(12)(l), any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice the licensee's profession.

ORDER

Based upon the foregoing Findings of Fact and Conclusion of Law, the parties agree to the provision and penalties imposed as follows:

1. As of the effective date of the Consent Agreement, Respondent shall not practice under his license.

2. Respondent's license, LCSW-3663, by rule, expired on 10/31/13.

3. Respondent agrees not to renew his license.

4. Respondent agrees not to submit any type of new license application to the Board for a minimum of five (5) years.

5. This Consent Agreement is conclusive evidence of the matters described herein and may be considered by the Board in determining appropriate sanctions in the event a subsequent violation occurs.

PROFESSIONAL ACCEPTS, SIGNS AND DATES THIS CONSENT AGREEMENT

Gary H. Straus — Date: 2/24/14

BOARD ACCEPTS, SIGNS AND DATES THIS CONSENT AGREEMENT

Dated this 2nd day of July, 2014.

By: _____
TOBI ZAVALA, Interim Executive Director
Arizona Board of Behavioral Health Examiners

ORIGINAL of the foregoing filed
This 2nd day of July, 2014 with:

Arizona Board of Behavioral Health Examiners
3443 N. Central Ave., Suite 1700
Phoenix, AZ 85012

COPY of the foregoing mailed via Interagency Mail
This 2nd day of July, 2014, to:

Beth Campbell
Assistant Attorney General
1275 West Washington
Phoenix, Arizona 85007

COPY of the foregoing mailed via
Certified mail no. 7014 0510 0001 3723 8363
This 2nd day of July, 2014 to:

Gary H. Straus
Address of Record
Respondent

Tobi Zavala

Tobi Zavala, Interim Executive Director
602-542-1617