STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF SOCIAL WORK
DISCIPLINARY SUBCOMMITTEE

In the Matter of

CHARLES ALEXANDER HUYCK, L.M.S.W.
License No. 68-01-070632,
Respondent.

Docket No. 17-014458
File No. 68-15-138073

FINAL ORDER

On December 2, 2016, the Department of Attorney General, on behalf of the Department of Licensing and Regulatory Affairs (Department), executed an Administrative Complaint charging Respondent with violating the Public Health Code, MCL 333.1101 *et seq.*

An administrative hearing was held in this matter before an administrative law judge who, on September 25, 2017, issued a Proposal for Decision (PFD) setting forth recommended Findings of Fact and Conclusions of Law.

On October 5, 2017, Respondent filed Exceptions to Proposal for Hearing Regarding Case 68-15-138073.

The Michigan Board of Social Work Disciplinary Subcommittee (DSC), having reviewed the administrative record, considered this matter at a regularly scheduled meeting held in Lansing, Michigan on November 28, 2017, and accepted the administrative law judge's Findings of Fact and Conclusions of Law contained in the PFD. Therefore,

IT IS ORDERED that for violating MCL 333.16221(a), (b)(i), (b)(iii), (b)(vi), (b)(x), and (f), Respondent's license to practice as a licensed master's social worker is REVOKED commencing on the effective date of this Order.

IT IS FURTHER ORDERED that reinstatement of a license which has been revoked is not automatic and in the event Respondent applies for reinstatement of the license, application for reinstatement shall be in accordance with MCL 333.16245 and 333.16247.

This Order is a public record required to be published and made available to the public pursuant to the Michigan Freedom of Information Act, MCL 15.241(1)(a); and this action may be reported to the National Practitioner Data Bank, and any other entity as required by state or federal law, in accordance with 42 USC 11101-11152.

IT IS FURTHER ORDERED that this Order shall be effective thirty days after the date signed by the DSC's Chairperson or authorized representative, as set forth below.

Dated: 12/26/17

MICHIGAN BOARD OF SOCIAL WORK
DISCIPLINARY SUBCOMMITTEE

By: _____
Cheryl Wykoff Pezon, Acting Director
Bureau of Professional Licensing
Authorized Representative

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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
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BOARD OF SOCIAL WORK
DISCIPLINARY SUBCOMMITTEE

In the Matter of

CHARLES ALEXANDER HUYCK, L.M.S.W.
License No. 68-01-070632
_____/ Complaint No. 68-15-138073

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Jessica A. Taub, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Charles Alexander Huyck L.M.S.W. (Respondent) alleging upon information and belief as follows:

1. The Board of Social Work, an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee.

2. Respondent is currently licensed to practice as a licensed master's social worker in Michigan pursuant to the Public Health Code.

3. Section 16221(a) of the Code provides the Disciplinary Subcommittee with authority to take disciplinary action against a licensee for violations of a general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or

not injury results, or any conduct, practice or condition which impairs, or may impair, the ability to safely and skillfully practice as a social worker.

4. Section 16221(b)(i) of the Code provides the Disciplinary Subcommittee with the authority to take disciplinary action against a licensee for incompetence, which is defined in section 16106(1) of the Code to mean "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs."

5. Section 16221(b)(iii) of the Code provides the Disciplinary Subcommittee authority to take disciplinary action against a licensee for a mental or physical inability reasonably related to and adversely affecting that licensee's ability to practice in a safe and competent manner.

6. Section 16221(b)(vi) of the Code provides the Disciplinary Subcommittee authority to take disciplinary action against a licensee for lack of good moral character. Good moral character is defined in MCL 338.41(1) as "the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner."

7. Section 16221(b)(x) of the Code provides the Disciplinary Subcommittee authority to take disciplinary action against a licensee that has received a final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States,

by the United States military, by the federal government, or by another country. A certified copy of the record of the board is conclusive evidence of the final action.

8. Section 16221(f) of the Code provides the Disciplinary Subcommittee authority to take disciplinary action against a licensee for failure to notify under section 16222(3) or (4) of the Code.

9. Section 16222(4) of the Code requires a licensee to notify the department of any disciplinary licensing or registration action taken by another state against the licensee within 30 days after the date of the action.

10. Section 16226 of the Code authorizes the Disciplinary Subcommittee to impose sanctions against persons licensed by the Board, if, after opportunity for hearing, the Disciplinary Subcommittee determines that the licensee violated one or more of the subdivisions contained in section 16221.

FACTUAL ALLEGATIONS

11. Respondent was employed as a social worker at Taylor Life Center in Owosso, Michigan from around May 2014 to January 2015.

12. J.R. received treatment from Respondent at Taylor Life Center on three occasions, November 18, 2014, December 8, 2014, and December 16, 2014.

13. On December 17, 2014, Taylor Life Center's Clinical Monitor received a complaint against Respondent based on his treatment of J.R. The report indicated Respondent spoke predominantly about himself during J.R.'s treatment sessions, and that Respondent made sexually inappropriate comments towards J.R. during these sessions.

14. After receiving this complaint, a Corporate Compliance Officer working on behalf of Taylor Life Center was assigned to investigate Respondent's treatment and work practices. During the course of the investigation, Respondent was only allowed to see patients if another staff member was present in the room with him.

15. As part of the Officer's investigation, he interviewed Respondent and Respondent's coworkers.

16. When Respondent was initially contacted by the Officer, Respondent was asked whether any of his patients would be reacting to him out of countertransference. Respondent replied to this statement, saying "all of them." Respondent also stated that two of his clients wanted to have a personal relationship with him, but he told them, "never in your lifetime" due to ethical concerns. Respondent then reported that there were three staff members he had sexual relations with. According to Respondent, he rejected two of those staff members, but had let the third back in.

17. The Officer then interviewed one of Respondent's coworkers who informed the Officer that Respondent had asked her out on dates even after she declined his advances. Respondent had also told her she needed to leave her fiancé, and that Respondent could feel her energy at home was unhappy. Respondent told this coworker that he knew she was suicidal, and that he cried for her at home because he could feel how unhappy she was. This coworker also reported that Respondent would tell her how high his libido was, and that he had the stamina of a

19 year old. This coworker stated that Respondent made sexual comments such as these about twice a week.

18. Another coworker of Respondent's was also interviewed. This coworker informed the Officer that Respondent normally makes sexual comments to her, such as telling her about his "sexual energy," and going into detail about "wild sex that he'd had." This coworker reported Respondent would discuss his sexual stamina with her as well, and that Respondent would inform her that he was performing "energy work" on her.

19. The Officer conducted a follow-up interview with Respondent, at which point Respondent informed the Officer that he had received an email from one of the company's billing specialists, and she had ended her email with "if you need anything else, please let me know." Respondent stated that he took that statement to mean she was "coming on to him."

20. Respondent then reported that one of his coworkers came into his office asking him if the noise from her prior session had bothered him because her patient had become upset and loud. Respondent interpreted this as the coworker being sexually involved with her patient.

21. One of the staff members, an unlicensed individual with no mental health training, sitting in on Respondent's therapy sessions was also interviewed. This coworker reported that Respondent would talk about himself and his divorce a lot during therapy sessions. Respondent would also frequently ask questions of a

sexual nature, and at one point turned to this staff member, and asked her to comment on a situation presented during a session with a patient.

22. Respondent's employment with Taylor Life Center was terminated on January 21, 2015 due to the Center's concern over Respondent's behavior and comments.

23. Complainant initiated an investigation into Respondent, and J.R.'s patient records were obtained. Complainant's expert reviewed J.R.'s patient records and made the following findings:

a. Respondent found J.R. presented with depression, but in the overall reading of J.R.'s patient records, Respondent's documentation was not consistent with a diagnosis of depression or treatment. J.R.'s symptoms indicating depression were not described other than a reference to J.R. experiencing problems sleeping.

b. Respondent documented J.R. reporting violence and abuse in her home. However, Respondent did not list the risks, or level of risk, J.R. may be encountering, nor did he specify a safety plan for J.R. In fact, at one point, Respondent declined to produce a safeguard plan for J.R., finding that J.R. is "too high functioning for this."

c. The only treatment methods Respondent documented for J.R. in terms of addressing her domestic violence issues included "therapy explanation, active listening and assessment." Respondent did not indicate how these methods would be integrated into addressing instances of domestic violence experienced by J.R.

d. Respondent did list some additional therapy techniques for J.R. such as dialectical behavior therapy, assertiveness training, and rational emotive therapy. However, Respondent did not tie the use of these modalities to any specific behavior or symptom experienced by J.R.

e. Respondent also listed relaxation therapy and systematic desensitization to treat J.R., but these treatment modalities were not supported by Respondent's description of J.R.'s problems.

f. Respondent listed four psychiatric medications prescribed to J.R. These medications include Lamicta, Clonipin, Seroquel and Lithium. However, Respondent did not address a consultation or collaboration with a prescribing physician or specify psychotherapeutic interventions to maintain symptom control.

24. During the course of the investigation into Respondent, it was also discovered that on September 10, 2013, Nebraska's Department of Health and Human Services, Division of Public Health filed a Petition for Disciplinary Action against Respondent's Nebraska credentials to practice as an Independent Mental Health Practitioner and Master Social Worker in the State.

25. The Nebraska Petition was based on Respondent's diagnosis of mental or emotional disability, and the allegation that Respondent's mental ailments impaired his ability to practice as a health professional in the State.

26. In resolution of the September 10, 2013 Nebraska Petition, Respondent voluntarily and permanently surrendered his credentials to practice as an Independent Mental Health Practitioner and Master Social Worker in Nebraska on January 10, 2014.

27. Respondent did not report his January 10, 2014 Nebraska disciplinary action to Complainant within 30 days of the date the action was taken.

COUNT I

28. Respondent's conduct, as described above, constitutes negligence in violation of section 16221(a) of the Code.

COUNT II

29. Respondent's conduct, as described above, constitutes incompetence in violation of section 16221(b)(i) of the Code.

COUNT III

30. Respondent's conduct, as described above, evidences a mental or physical inability reasonably related to and adversely affecting Respondent's ability to practice in a safe and competent manner in violation of 16221(b)(iii) of the Code.

COUNT IV

31. Respondent's conduct, as described above, constitutes a lack of good moral character in violation of 16221(b)(vi) of the Code.

COUNT V

32. Respondent's voluntary and permanent surrender of his Nebraska license constitutes a final adverse action taken by another licensure, registration, disciplinary, or certification board in the United States in violation of 16221(b)(x) of the Code.

COUNT VI

33. Respondent's failure to notify Complainant of the January 10, 2014 Nebraska action within 30 days from the date the action was taken, contrary to section 16222(4) of the Code, constitutes a violation of and 16221(f) of the Code.

THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not

shown, Complainant further requests that formal proceedings be commenced pursuant to the Public Health Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq.*

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned assistant attorney general. Further, pursuant to section 16231(9), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully Submitted,

BILL SCHUETTE
Attorney General

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Dated: December 2, 2016

LF: 2016-0138304-B/Huyck, Charles Alexander, L.M.S.W. - 138073/Complaint – 2016-12-02