LOUISIANA BEHAVIOR ANALYST BOARD

IN THE MATTER OF
DR. CAROLYN BARAHONA

COMPLAINT NUMBER: 2020-001B
LICENSE NUMBER: L-015

FINDINGS OF FACT AND CONCLUSIONS OF LAW FOR ORDER OF SUMMARY SUSPENSION

Louisiana Behavior Analyst License Number L-015, issued to Dr. Carolyn Barahona, was summarily suspended by Order of Summary Suspension dated May 26, 2020, pending an administrative hearing before the Louisiana Behavior Analyst Board (hereinafter referred to as "the Board") in compliance with La. R.S. 37:3704(9), LAC Title 46, Part 8:604, and the Louisiana Administrative Procedure Act, La R.S. 49:950, *et.seq*. The Board initiated an investigation Dr. Barahona after she self-reported that a lawsuit, alleging various acts of negligence related to the therapy provided to client, DL, had been filed on January 29, 2020.

The results of the investigation caused the Disciplinary Committee to believe that Dr. Barahona's possession of a LBA license presents an imminent danger to the public health, safety, and welfare. A hearing on the summary suspension, originally scheduled for June 5, 2020, came before the Board on July 6 - 7, 2020, as a result of a Consent Judgement entered on June 1, 2020.

The Board considered the Committee's recommendation to summarily suspend Dr. Carolyn Barahona, PH.D., LBA, alleging violations of the Louisiana Behavior Analyst (LBA) Practice Act, La. R.S. 37:3701 *et. seq.*, the Board's rules and regulations, the Behavior Analyst Certification Board (BACB) Professional and Ethical Compliance Code for Behavior Analyst, and that Dr. Carolyn Barahona poses an imminent danger to the public if she is allowed to continue to practice.

The following Board members, which included an ad hoc member, were present and constituted a quorum: Dr. Lloyd Boudloche, Board Chair, Courtney Wright, Renee Cole, Calvin Cryer, Angela Murray, and Emily Bellaci, *ad hoc* member. Dr. Carolyn Barahona, represented by Ashley Heilprin and Allen Miller, was present and participated in the hearing. Other appearances included:

Larry Roedel, Hearing Officer;

James R. Raines and Alex Hains, complaint counsel for the Board;

Alicia Edmond Wheeler, general counsel for the Board;

Ellen Brocato, complaints coordinator for the Board, appearing as a witness; and

Alfred Tuminello, Chair of the Board Disciplinary Committee, appearing as a witness.

As required by La. R.S. 37:3704(9), the information, including the following allegations, were presented to the Board to consider whether summary suspension was warranted:

1. Dr. Barahona directed her supervisees to provoke behaviors in clients with Autism while working at GSAC;
2. Dr. Barahona failed to appropriately supervise Registered Line Technicians registered under her licensee, who reportedly bullied and handled clients in a hostile and harsh manner. The Registered Line Technicians working under Dr. Barahona were observed by other GSAC staff shoving, grabbing wrists, force-feeding, antagonizing tantrums and using verbally abusive language toward clients;
3. Dr. Barahona failed to provide contracted and paid-for services;
4. Dr. Barahona failed to adequately supervise Registered Line Technicians at GSAC, and promoted unqualified individuals into supervisory roles at GSAC;
5. Dr. Barahona failed to adequately train Registered Line Technicians of GSAC;
6. Dr. Barahona failed to adequately monitor the activities of Registered Line Technicians of GSAC;

7. Dr. Barahona failed to implement appropriate ABA protocols and treatment for client John Doe (as named in the lawsuit) and/or adjust them as they were unsuccessful;

8. Dr. Barahona advised employees and/or independent contractors and staff of GSAC to mislead parents about their child's progress or lack thereof, including but not limited to hiding portions of client data sheets from the parents;

9. Dr. Barahona failed to directly supervise and train Registered Line Technicians;

10. Dr. Barahona failed to spend an adequate amount of time in the client's classes;

11. Dr. Barahona failed to address John Doe's obvious physical and behavioral decline;

12. Dr. Barahona failed to provide John Doe with attainable goals;

13. Dr. Barahona failed to timely collect accurate natural data and track the behaviors and skill levels of John Doe to determine the appropriate curriculum, instead collecting data skewed by data protocol;

14. Dr. Barahona failed to implement positive reinforcement techniques due to the excessive implementation of behavioral protocol;

15. Dr. Barahona failed to curb her RLT's excessive focus on eliminating behaviors they considered problematic, and failure to require development of new skills and behaviors;

16. Dr. Barahona failed to prevent the improper, excessive, cruel, and pointless punishment of John Doe under the guise of ABA services;

17. Dr. Barahona failed to provide the parents of John Doe with accurate information regarding what was happening with him while at GSAC, including but not limited to withholding portions of client data sheets, and withholding information regarding the implementation of "Behavioral Protocol";

18. Dr. Barahona failed to comply with Louisiana law regarding reporting suspected abuse;

19. Dr. Barahona failed to properly investigate allegations of misconduct and abuse, including failure to properly advise and provide the parents of John Doe with the complete and/or written results of the investigation into her conduct, as well as the conduct of Registered Line Technicians registered under her license;

20. Dr. Barahona failed to provide to the LBAB accurate information when making a self-report regarding alleged unethical conduct in 2019;

21. Dr. Barahona failed to provide accurate information regarding the self-injurious behavior of John Doe to the insurance company when detailing his Plan of Care upon seeking a renewal of services.

The Board received oral testimony and documentary evidence submitted by both parties.

Having considered the Disciplinary Committee's recommendation, witness testimony, evidence,

and the law, rules and regulations applicable to licensees, the Board finds, concludes, and orders the following:

FINDINGS OF FACT:

1. Dr. Barahona holds LBA license number L-015 with the LBAB. At all times relevant to these proceedings, Dr. Barahona was a partner at Gulf South Autism Center (GSAC). GSAC provides applied behavioral analysis services to children with autism. GSAC operates three locations – New Orleans, Metairie, and Baton Rouge, Louisiana. Dr. Barahona practiced at GSAC's New Orleans location.

2. The Board initiated an investigation of Dr. Barahona after she self-reported that a lawsuit, alleging various acts of negligence related to the therapy provided to DL, had been filed against her and GSAC on January 29, 2020. Dr. Barahona denied any wrongdoing.

3. DL is a non-verbal, autistic, minor child who began receiving services at GSAC in January 2017.

4. While at GSAC, DL began exhibiting self-injurious behavior (SIB) in 2017, of which Dr. Barahona was aware.

5. Dr. Barahona began tracking DL's SIB in April 2018.

6. On June 22, 2018, Dr. Barahona documented 236 instances of DL's SIB.

7. In February 2019, Dr. Barahona documented several days of SIB, ranging from 65 – 1,222 instances. Dr. Barahona had not yet developed a Behavior Reduction Plan for DL.

8. Between March 20 – 24, 2019, DL exhibited over 500 instances of SIB each day.

9. On several occasions in April 2019, DL exhibited over 2000 instances of SIB. On April 3, 2019, DL had over 2,200 incidences, on April 4, 2019, 2,225 instances, and on April 5, 2019, 2,878 instances of SIB.

10. Dr. Barahona did not develop a behavior support plan for DL until the end of April 2019.

11. Dr. Barahona did not perform a functional analysis of DL's problem behavior(s).

12. Dr. Barahona failed to implement interventions to address DL's SIB.

CONCLUSIONS OF LAW

In light of the facts presented to the Board, it is clear that Dr. Carolyn Barahona poses an imminent danger to the public health, safety and welfare if Dr. Barahona were allowed to continue to practice. Further, due to the nature of the complaint against Dr. Barahona, emergency action was required. Therefore, the Board, by unanimous vote, finds and concludes that the action taken to summarily suspend LBA License Number L-015, issued to Dr. Carolyn Barahona, was warranted.

Accordingly, and for the reasons as stated in the Order of Summary Suspension dated May 26, 2020:

IT IS ORDERED that in accordance with the recommendation of the Disciplinary Committee, Louisiana Behavior Analyst License Number L-0159, issued to Dr. Carolyn Barahona, is hereby **SUMMARILY SUSPENDED**, effective May 26, 2020, pending further investigation and formal proceedings for revocation of licensure or other action the Board deems fit.

IT IS FURTHER ORDERED that this Findings of Fact and Conclusions of Law for Order of Summary Suspension is a public document and shall be reported to such public or private entities as required by law. This Order is not a final agency action.

BY ORDER OF THE BOARD

Courtney B. Wright

DR. COURTNEY WRIGHT,
BOARD CHAIR
LOUISIANA BEHAVIORAL ANALYST BOARD
~~FEBRUARY 17, 2021~~
APRIL 20, 2021