DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
[Name Redacted]	)	ISCR Case No. 17-04028
	)	
Applicant for Security Clearance	)	

Appearances

For Government: Andre M. Gregorian, Esq., Department Counsel
For Applicant: *Pro se*

02/14/2019

Decision

MATCHINSKI, Elizabeth M., Administrative Judge:

Applicant relapsed into abusing alcohol in 2005 after 20 years of abstinence. He continued to drink alcohol against medical advice until as recently as July 2017, despite several inpatient alcohol-detoxification treatments and counseling programs for diagnosed alcohol abuse disorder, severe. He is presently committed to Alcoholics Anonymous (AA), but it is too soon to conclude that his maladaptive use of alcohol will not reoccur. Clearance is denied.

Statement of the Case

On May 30, 2018, the Department of Defense Consolidated Adjudications Facility (DOD CAF) issued a Statement of Reasons (SOR) to Applicant, detailing the security concerns under Guideline G (alcohol consumption), Guideline H (drug involvement and substance misuse), Guideline I (psychological conditions), and Guideline F (financial considerations). The SOR explained why the DOD CAF was unable to find it clearly consistent with the national interest to grant or continue security clearance eligibility for him. The DOD CAF took the action under Executive Order (EO) 10865, *Safeguarding Classified Information within Industry* (February 20, 1960), as amended; DOD Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (January 2,

1992), as amended (Directive); and the National Security Adjudicative Guidelines (AG) effective June 8, 2017, to all adjudications for national security eligibility or eligibility to hold a sensitive position.

Applicant answered the SOR allegations on June 6, 2018, and requested a hearing before an administrative judge from the Defense Office of Hearings and Appeals (DOHA). On September 7, 2018, the case was assigned to me to conduct a hearing to determine whether it is clearly consistent with the national interest to grant or continue a security clearance for Applicant. On October 5, 2018, I scheduled a hearing for November 14, 2017.

At the hearing, the Government withdrew the Guideline F allegation (SOR ¶ 4.a) before the introduction of any evidence. Ten Government exhibits (GEs 1-10) were admitted in evidence without objection. Four documents were marked as hearing exhibits (HEs I-IV) for the record but not admitted as evidentiary exhibits: a June 28, 2018 letter (HE I) and a November 5, 2018 email (HE II) forwarding discovery of the GEs; an index of the GEs (HE III); and a list prepared by Department Counsel relating the GEs to the SOR allegations (HE IV). Two Applicant exhibits (AEs A-B) were admitted in evidence. Applicant testified, as reflected in a transcript (Tr.) received on November 27, 2018.

Summary of Pleadings

The amended SOR alleges that under one or more of AGs G (SOR ¶ 1), H (SOR ¶ 2), and I (SOR ¶ 3) the following:

- Applicant was admitted to a hospital in May 2009 for alcohol detoxification and diagnosed with alcohol abuse disorder and heroin abuse disorder (SOR ¶¶ 1.a and 2.a);

- Applicant was treated from September 2012 to November 2016 for diagnosed opioid dependence, alcohol dependence, and major depression (SOR ¶¶ 1.b, 2.a, and 3.a);

- Applicant was admitted to a hospital in January 2015 (SOR ¶ 1.c) and in June 2015 (SOR ¶ 1.d) for alcohol detoxification and diagnosed with alcohol abuse disorder;

- Applicant was admitted to a hospital on two separate occasions in July 2016 for acute alcohol intoxication, *i.e.*, he was transported by ambulance on July 7, 2016, after he appeared drunk at a local store (SOR ¶ 1.e(i)), and he was taken by his daughter to a hospital on July 20, 2016 and referred to another hospital for detoxification where he was diagnosed with alcohol use disorder, severe (SOR ¶ 1.e(ii));

- Applicant was admitted to a hospital for acute alcohol intoxication in September 2016 where he was diagnosed with alcohol use disorder, severe, and alcohol dependence and referred for detoxification (SOR ¶ 1.f);

- Applicant was admitted to a hospital for alcohol reasons on four separate occasions in October 2016, *i.e.*, he was taken by a local fire department on October 5, 2016, after expressing suicidal ideation, and was diagnosed with alcohol abuse disorder and depression (SOR ¶¶ 1.g(i) and 3.a); he admitted himself on October 6, 2016, for detoxification and psychological evaluation and was diagnosed with alcohol abuse disorder and depressive disorder (SOR ¶¶ 1.g(ii)and 3.a); he requested alcohol detoxification on October 19, 2016 (SOR ¶¶ 1.g(iii)); and he was taken by a local fire department on October 31, 2016, after expressing suicidal ideations, and was diagnosed with alcohol intoxication and depression (SOR ¶¶ 1.g(iv) and 3.a.);

- Applicant sought substance-abuse treatment in December 2016 and was diagnosed with alcohol use disorder, severe, and opioid use disorder, severe—in early remission (SOR ¶¶ 1.h and 2.a); and

- Applicant was diagnosed by a duly-qualified medical professional in October 2017 with alcohol use disorder, severe—in early remission and adjustment disorder with depressed mood (SOR ¶¶ 1.i and 3.a).

When he responded to the SOR, Applicant admitted the allegations with one exception. He denied the diagnosis of heroin abuse disorder in 2009. He submitted no explanations.

Findings of Fact

Applicant's admissions to the alcohol, opiate, and mental health-related diagnoses and to his various treatments are accepted and incorporated as factual findings. After considering the pleadings, exhibits, and transcript, I make additional findings of fact as follows.

Applicant is a 63-year-old research and development mechanic who has worked for his defense-contractor employer since January 2003. He has held a secret clearance since April 2003. (GE 1; AE A; Tr. 33.)

Applicant and his spouse met in AA in 1985 and married in 1987. They were separated in 1994 but reconciled in 2004. They have been legally separated since April 2016 because of his drinking. They have a 29-year-old son who lives with Applicant and has a ten-year-old son of his own. Applicant's spouse has two grown daughters from a previous relationship whom Applicant adopted and raised as his own children. (GE 1; Tr. 33-37.)

Applicant began consuming alcohol at age 14. From 1969 until he turned of legal age to drink in 1973, he drank two beers or a half-bottle of wine monthly with friends. Over the next decade, he drank 6 to 12 beers twice weekly. In 1984, he began drinking daily, consuming six beers at a sitting in his home or at bars with friends. In 1985, Applicant recognized that he was drinking too much. Following completion of an alcohol-rehabilitation program, he attended AA meetings until 2001 or 2002. He eventually drifted away from AA, but stayed abstinent from alcohol for some 20 years until 2005. (GE 10; AE A.) He started drinking periodically on business trips with his co-workers. Before long, he was consuming alcohol on weekends in quantity of two to three beers or shots of liquor with dinner. He concealed his drinking from his spouse because he knew she would disapprove of his drinking. (GE 2.)

In 2006 or 2007, Applicant was prescribed a narcotic for pain from a local orthopedist for a condition misdiagnosed as sciatica. Applicant has variously reported that, after two to three months of taking his pain medication as prescribed, he began illegally obtaining and using narcotics and OxyContin. He reported illegally using Vicodin on a weekly basis for five to six months and OxyContin daily for four months, which he obtained from friends and associates. (GE 10; AE A.) Medical records from 2009 indicate more extensive abuse of narcotics and opiates. (GEs 3-4.) Applicant acknowledged at his hearing that he abused prescription pain medications (Vicodin and OxyContin) from 2007 to May 2009 (Tr. 48-49) and that he also used heroin a few times when he could not illegally obtain OxyContin. (Tr. 51.) Most of the time, he obtained the prescription painkillers from friends and did not have to pay for the drugs. However, he also testified that he spent $5,000 to $6,000 for the drugs over the two years he abused them. (Tr. 56-57.)

Applicant missed a couple of days of work in May 2009 because of his polysubstance abuse. On May 18, 2009, Applicant's spouse brought him to the emergency department of a local hospital seeking help for his alcohol problem. His blood-alcohol level tested at .285%. He told medical staff that he had resumed alcohol consumption about five years ago; that his drinking had gotten out of control in the past few months; and that in the last three weeks, he had consumed a pint of schnapps per day. He also admitted that he had been abusing opiates. Medical records indicate that he reported abusing opiates (OxyContin, Fentanyl patches,[1] and some heroin) for the past three years to self-medicate for pain, with his most recent use being on the weekend preceding his presentation in the emergency department. Applicant was diagnosed with alcohol dependence, opioid abuse, and alcohol intoxication, and referred to a hospital specializing in mental health and addictions treatment (hospital X) for alcohol-detoxification treatment. (GEs 3-4.)

Applicant received voluntary alcohol-detoxification and opioid-detoxification treatment at hospital X from May 19, 2009, to May 26, 2009. He reported to clinicians that he began taking prescribed Percocet for pain about two years prior, and that when his prescription ran out three weeks later, he began obtaining pain medications from friends

[1] Applicant asserts that he used a Fentanyl patch only one time. (Tr. 51, 54.) He admitted that he used heroin when he could not obtain OxyContin and used heroin twice in May 2009. (Tr. 51-52.) Applicant acknowledged that he had a DOD clearance when he engaged in illegal drug use. (Tr. 55.)

and acquaintances. He reported illegally taking 60 mg. of OxyContin per day since then with some increase to 80 mg. daily in the last year. Applicant stated that, at times, he used "half a bundle of heroin per day."[2] He reported using heroin twice, and OxyContin and a Fentanyl patch once during the May 15-17, 2009 time frame. He stated that he had also been consuming 1.5 pints of vodka per day for the last two years. Applicant expressed concern about the possible loss of his job if he continued to drink. Diagnoses on admission were alcohol withdrawal, alcohol dependence, opioid withdrawal, and opioid dependence. He appeared motivated to cease his alcohol and opioid abuse, and was safely detoxified from both substances. He transitioned to the facility's partial hospitalization program (PHP) on Suboxone[3] and Trazodone with a fair prognosis if he became engaged in outpatient treatment. (GE 4.)

While at hospital X, Applicant began a therapeutic relationship with a psychiatrist. She placed Applicant on Suboxone for his opiate abuse, and she had individual counseling with Applicant weekly to twice weekly in 2009 and then monthly until August 2016, when she terminated their relationship after finding out that he had been drinking alcohol while taking Suboxone. Applicant knew he was required to abstain from alcohol while on Suboxone. (GEs 1, 4, 10; Tr. 59.)

On January 6, 2015, Applicant went to his local emergency department complaining of leg atrophy and weakness. He acknowledged that he was drinking approximately ten shots of alcohol per day while taking prescribed Suboxone, but expressed no interest in alcohol detoxification unless it would help his leg. He was diagnosed with alcohol abuse and discharged in stable condition, but advised to decrease his alcohol intake. (GE 3.)

On June 11, 2015, Applicant presented at the emergency department with moderate alcohol abuse. He reported that he had been binge drinking for the past week and wanted alcohol-detoxification treatment at hospital X. He was discharged from the emergency department in stable condition. (GE 3.)

Applicant had alcohol-detoxification treatment at hospital X from June 11, 2015, to June 15, 2015. On admission, he admitted he had been drinking four to nine "nips"[4] on the weekends with an increase over the past week to at least six or more drinks ("shots of bourbon" and "nips") per day to intoxication while taking Suboxone. Applicant reported missing several days of work recently because of his alcohol use, although he had the leave to cover his lost time and was not reprimanded. (Tr. 73.) He exhibited some

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[2] Applicant testified that he was never addicted to heroin. He knew that heroin and OxyContin were both opiates and he told clinicians that he was buying a bundle of heroin per day because it was a way for him to get accepted into the Suboxone program. (Tr. 50.)

[3] Suboxone is a combination of two narcotics, buprenorphine and naloxone, both partial opiate agonists. It was approved for the treatment of opioid dependence by the Food and Drug Administration in 2002. According to studies from the National Institute of Health, people addicted to prescription painkillers reduced their opioid abuse when given sustained treatment with Suboxone, which reduces withdrawal symptoms. *See* www.nih.gov.

[4] Applicant testified that he drank as many as ten shots per day. Applicant's "nips" were the small bottles of liquor containing 1.5 ounces. (Tr. 74-75.)

symptoms of alcohol withdrawal, including tremors. He reported that he was actively involved in AA "as a sponsor," and he expressed a desire to attend AA meetings on his discharge. He was discharged in stable condition to continue to take Suboxone and follow up with his psychiatrist. Diagnoses at discharge included alcohol dependence, continuous, and opioid dependence, in remission. (GE 4.)

In 2015, Applicant's psychiatrist closed her private practice for a clinic affiliation. Applicant began outpatient counseling with a therapist at the clinic in September 2015 for his diagnosed opioid use disorder, severe, in sustained remission; depressive disorder; and alcohol dependence. Applicant reported abstinence from alcohol and some improvement in his depression after being placed on mood stabilizers. His psychiatrist continued to prescribe Suboxone for his opioid use disorder and pain relief, and she prescribed Campral medication for alcohol cravings. In early January 2016, Applicant told his psychiatrist that he had thought about drinking a few times, but that he had maintained sobriety. Applicant was advised to attend AA. Applicant reported during counseling sessions in late February 2016 and early May 2016 that he was still not drinking, although he now acknowledges that he continued to drink alcohol on weekends and hide his alcohol use from his psychiatrist. (Tr. 64.) His mood was noted as stable on Cymbalta, although he was stressed about a new home purchase. During a session at the clinic in mid-June 2016, Applicant reported that he had stopped taking Campral and that family stress had led him to drink alcohol. He was advised to take Campral, engage in counseling, and attend AA. His opioid dependence was in remission. (GE 7.)

On July 4, 2016, Applicant began drinking heavily due to chronic pain. Three days later, Applicant was transported by ambulance to his local emergency room because of alcohol intoxication. He smelled of alcohol and his speech was slurred. He chose to leave the hospital against medical advice, and he was discharged to his wife's custody. (GE 3.) Applicant was unable to work because of his pain, and he went on short-term disability, which lasted nine months. (GEs 3, 9; Tr. 47.)

On July 16, 2016, Applicant called his counselor at the outpatient clinic. He was intoxicated and was told he needed a higher level of care than the clinic could provide. He was discharged from his outpatient therapy at the clinic on July 20, 2016, but allowed to remain in medication management with his psychiatrist as long as he sought a higher level of care. Diagnoses at the time of his discharge from the clinic were opioid dependence, on antagonist therapy, and alcohol abuse. (GE 7.)

On July 20, 2016, Applicant was transported by his daughter to his local hospital. He was diagnosed in the emergency department with acute alcohol intoxication and alcoholism. He reported two weeks of heavy drinking and steady drinking of approximately a liter of vodka per day for the past five days. Urine screens were negative for opiates, but his blood-alcohol levels were critically high. He had withdrawal symptoms from alcohol, including anxiety and tremors. Applicant was transferred to hospital X for alcohol-detoxification treatment on July 21, 2016. (GE 3; Tr. 75.)

Applicant told staff at hospital X that he had been consuming two pints of peppermint schnapps per day and that his increased drinking was precipitated by an argument with his wife and their subsequent marital separation. Applicant was diagnosed with alcohol use disorder, severe. Treatment was attempted with benzodiazepines for a few hours, but he was tremulous, agitated, and hallucinating. He was transported back to his local hospital for medical treatment of suspected delirium tremens. (GEs 3-4.)

On July 22, 2016, Applicant was readmitted to hospital X for alcohol-detoxification treatment. Notes of an attending psychiatrist indicate that Applicant was involved in AA and was an AA sponsor. He was successfully detoxified from alcohol using the hospital's standard protocol. At discharge on July 28, 2016, Applicant was prescribed Suboxone and urged to maintain sobriety. Aftercare plans included continuing with his outpatient counseling at the clinic and medication management with his psychiatrist. (GE 4.) Applicant stayed sober for ten days only to again relapse into drinking alcohol. (GE 6.)

During a medication-management session with his psychiatrist on August 2, 2016, Applicant exhibited moderate symptoms of anxiety and depression. The psychiatrist assessed his progress in treatment as minimal, given he had relapsed with alcohol. She advised him to contact hospital X as soon as possible about its intensive outpatient program (IOP). She noted his need for Suboxone to prevent withdrawal and relapse into opioid dependence, recommended counseling for diagnosed major depressive disorder, and ended her treatment with him. (GE 7.)

During the morning of September 6, 2016, Applicant was brought to his local hospital by his son. Applicant was intoxicated at the time. He reported consuming ten or more alcohol drinks per day and also feeling that his life was out of control. (Tr. 75.) He attributed his relapse to being discharged from his Suboxone protocol. He went into withdrawals that triggered his relapse. He was seen as ambivalent about his sobriety and lacking insight into his situation. He was transferred to hospital X for alcohol-detoxification treatment. (GEs 3, 6.)

Applicant was treated at hospital X from September 6, 2016, through September 12, 2016. He reported symptoms of helplessness. His treatment plan addressed symptoms of anxiety, depression, and substance abuse. On September 13, 2016, he was transferred to the hospital's IOP consisting of clinical group therapy five days per week with the goal of relapse prevention. On admission to the IOP, he was diagnosed with alcohol use disorder, severe; unspecified anxiety disorder; and unspecified depressive disorder. While in the IOP, Applicant was engaged in clinical group therapy, and he admitted that he had stopped attending AA, which led to his relapse. He expressed a willingness to return to AA and a desire to remain sober. Over the next few days, he reported no substance use, but he was considered to be at risk for relapse. On September 15, 2016, Applicant was evaluated by a physician for medication management. Applicant denied any suicidal ideation, and his judgment and insight were assessed as fair. He met diagnostic criteria for severe alcohol use disorder and severe opioid use disorder. The physician recommended that he continue with the IOP and regular AA meetings. Applicant continued to attend his IOP group-therapy sessions, showing receptivity to treatment interventions, but also some depression and

anxiety. He reported attending AA meetings and contacting his sponsor. He remained concerned about being at home alone, which was a trigger for his abuse. As of September 29, 2016, he reported attending at least four AA meetings a week. (GE 6.) Despite his involvement in AA, he was unable to stop drinking. (Tr. 64.)

On October 5, 2016, Applicant was transported by ambulance to his local hospital for suicidal thoughts and alcohol intoxication. He had been drinking "as much as he could" over the previous five to six days after his son was involved in a car accident. Applicant was diagnosed with alcohol abuse and depression. Applicant initially denied he had been drinking and was belligerent with staff. He was medically cleared for discharge to home that evening with the recommendation that he continue in his IOP at hospital X. As soon as Applicant arrived home, he drank alcohol. (GE 3.)

On October 6, 2016, Applicant went to his IOP and reported that he wanted to kill himself. He went to his local hospital's emergency department for a mental-health evaluation, which was not conducted at that time because he was not sober. (GE 3; Tr. 62.) Available medical records indicate that Applicant was then treated at hospital X until October 10, 2016. (GE 6.)

Applicant resumed his participation in his IOP on October 11, 2016. He was remorseful about his latest relapse and indicated that he was actively returning to AA. He was motivated to stay sober but admitted that he struggled on the weekends when alone at home. Applicant reported significant issues with irritability and depression and being overwhelmed by health and financial concerns. (GE 6.)

After drinking heavily for three days, on October 18, 2016, Applicant went to his local hospital requesting a placement for alcohol detoxification. He did not exhibit any signs or symptoms consistent with alcohol withdrawal and was referred to his IOP. (GE 3.) At the referral of his therapist, Applicant received alcohol-detoxification treatment at a different hospital from October 19, 2016, to October 25, 2016. He admitted that he drank alcohol on most Saturdays and exhibited blunted affect with depressed and anxious mood, but he also appeared committed to sobriety. His judgment and insight were assessed as impaired. Following an uncomplicated inpatient detoxification, he was discharged in improved condition with a primary diagnosis of alcohol use disorder with uncomplicated withdrawal; depressive disorder, unspecified; and obsessive compulsive disorder trait. He was prescribed an anti-depressant, advised to follow-up in his IOP program, and given a referral to an inpatient 28-day alcohol-rehabilitation program. (GE 9.)

Instead, Applicant resumed his participation in his IOP. He appeared frustrated by his recent detoxification stay and indicated that he had declined the referral to the rehabilitation facility because of the cost. Applicant testified that he had no guarantee of a bed. (Tr. 79.) In the IOP, Applicant struggled to accept responsibility for his sobriety. (GE 6.)

On October 31, 2016, Applicant was transported by the local fire department to his local hospital's emergency department for a mental health evaluation. Applicant was

diagnosed with alcohol intoxication, depression, and suicidal ideation. He possessed a gun and expressed fear that he might kill himself.[5] Applicant told medical personnel that he had been drinking seven to nine alcohol drinks on a daily basis for the last five days. He had a mental-health assessment on November 1, 2016, and was considered stable for discharge. He was given a referral to a 28-day inpatient alcohol-rehabilitation program in a distant state with treatment to be at no cost to him. (GE 3.)

Applicant declined the referral and resumed his participation in hospital X's IOP on November 3, 2016. He advised his therapist that he declined residential treatment because it was too far away, he had bills to pay, and he had to care for his son. Applicant was depressed, but he had no suicidal thoughts. He expressed an intention to attend an AA meeting daily and several AA meetings on the weekends to offset triggers. He was persuaded to attend a PHP more tailored to substance abuse. (GE 6.)

Applicant reported to the PHP on November 4, 2016, as "clean and safe and sober." Similar to his IOP, his treatment plan included attending at least 20 support meetings per week for treatment of alcohol use disorder, severe, to work on identifying triggers for his substance abuse and to learn coping skills. In addition, he received psychological education and had psychiatrist appointments as needed with a focus on alcohol recovery, and depression and anxiety management. His anxiety was high at times because of external stressors, including a lack of funds. His short-term disability income was less than his regular income, and he was not able to work because of chronic knee pain. He appeared motivated for sobriety and remained alcohol and drug-free. All toxicology screens were negative. He attended AA daily and had a sponsor in AA and was receptive during his group therapy sessions. Applicant was transferred back to the IOP on November 9, 2016. On November 23, 2016, he was successfully discharged from the IOP with diagnoses of alcohol use disorder, severe; unspecified anxiety disorder; and unspecified depressive disorder (provisional). He reported no longer experiencing anxiety or depression. In the opinion of his primary therapist, Applicant had demonstrated the ability to use several new coping skills. His therapist also noted that Applicant's main source of sobriety was his "strong connection" with AA. Applicant was discharged with a good prognosis to continue in aftercare consisting of individual therapy and medications for his anxiety. (GE 5.)

Applicant had an intake session for counseling with an addiction-recovery service on December 1, 2016, Applicant reported a history of abusing alcohol and prescription medications; sobriety for 20 years with the help of AA after completing an inpatient program at age 29; but then drinking on and off after going on a "road job" for his employer. He attributed an increase in his drinking after he was cut off from Suboxone six months ago. At its worst, he drank 13 to 15 nips every night, but he reported no drinking for the past 36 days. He admitted that he had spent "thousands" on opiates in the past. He denied significant symptoms of depression or anxiety. He was diagnosed with alcohol use disorder, severe, and with opioid use disorder, severe, in early remission. Applicant participated in two individual therapy sessions and two group therapy sessions in

[5] Applicant now maintains that it was a BB gun. (Tr. 62.) He believes his depression and suicidal ideation were a product of his heavy drinking. (Tr. 65.) Applicant testified that when he was not working, "there was no reason not to drink during the day." (Tr. 76.)

December 2016. Available medical records from the provider reflect that his treatment was expected to end in June 2017. (GE 8; Tr. 75.) The last available progress note from the facility is January 4, 2017. (GE 8.) Applicant testified that he completed the counseling in June 2017 (Tr. 80), but he also told a clinical psychologist during an October 8, 2017 evaluation for the DOD that he stopped treatment because his insurance would no longer pay for his sessions. (GE 2.)

On January 5, 2017, Applicant was interviewed by an authorized investigator for the Office of Personnel Management (OPM). Applicant asserted that he abstained completely from alcohol from 1985 until 2005, but from 2005 to March 2016, he drank two or three beers or shots of liquor on the weekends. He hid his alcohol consumption from his wife, whom he met in AA, and also from his treating psychiatrist because he knew that she would discontinue his Suboxone medication if he was drinking. He stated that he drank two to three nips of liquor three times a week after work from March 2016 to April 2016, when his spouse left him because of his drinking. He then drank daily, although only one to two nips per day until July 2016 when his drinking increased to six to eight shots of liquor on the weekends. He claimed he stopped drinking in September 2016 because he started attending AA, and he denied any intention to drink alcohol in the future. He acknowledged that he had been diagnosed as alcohol dependent, but also stated that he did not consider himself to be alcohol dependent. Applicant discussed his recent treatments for his alcohol use. With regard to the concerns that he was suicidal in October 2016, Applicant denied that he was suicidal and explained that he had been discouraged because he could not stop drinking. He was in addictions counseling, and had been going to AA once or twice a day since October 2016. He reported an intention to continue with his addictions counseling and with AA. (GE 10.)

Regarding his misuse of opiates, Applicant acknowledged that he had illegally used Vicodin and OxyContin, although he indicated that his abuse was limited to five or six months for Vicodin and four months for OxyContin starting in 2008. After receiving detoxification treatment for five days for diagnosed addiction to opiates, Applicant was prescribed Suboxone, which he took for the next eight years. Applicant acknowledged that alcohol was contraindicated with Suboxone, and that after he tested positive for alcohol in a urine screen in July 2016, his psychiatrist terminated the Suboxone. (GE 10.)

On January 12, 2017, Applicant met with the OPM investigator to provide further information about his alcohol treatments. He explained that his therapist wanted him to attend a long-term recovery program, but he chose to be treated at a more local hospital for detoxification in October 2016. As for his previous claim that he had stopped drinking in September 2016, he stated that his therapist told him that he had to drink in order to be admitted, and so he consumed six nips before his admission for treatment in mid-October 2016. (GEs 9-10.)

Applicant remained abstinent from alcohol while attending about nine AA meetings a week. He had surgery in January 2017, which proved effective in alleviating his chronic pain. He took prescribed painkillers after his surgery with no misuse of prescription drugs. (Tr. 47.) He returned to work from disability in April 2017 (AE A; Tr. 46), but mounting

financial issues,[6] including federal and state tax delinquencies (Tr. 81), and problems with his son led Applicant to feel depressed and overwhelmed. His son was abusing illegal drugs (including crack cocaine and heroin), taking his money, and intimidating him. Applicant turned to alcohol to cope in June 2017. He consumed four to five nips of whiskey the first day followed by daily drinking of as much as a pint of liquor. After three weeks of heavy drinking, he called his spouse in early July 2017, and she took him to the hospital. He was transferred to hospital X where he received inpatient treatment from July 7, 2017, to July 14, 2017, for major depressive disorder, alcohol withdrawal, alcohol dependence, and suicidal ideation.[7] He was on suicide watch briefly, but he asserts that he only expressed suicidal ideation at his spouse's suggestion to ensure that he would be admitted for alcohol treatment. (GE 2; Tr. 81-83.) Applicant now believes that his depression and suicidal ideation were a product of his heavy drinking. (Tr. 65.) Applicant was discharged to the hospital's IOP where he attended counseling three nights per week for about five weeks. (GE 2.)

During Applicant's inpatient stay at hospital X, his counselor filed a report of elder abuse about his son's behavior. The state's child protective services became involved because Applicant's son has physical custody of his ten-year-old child four days a week. It motivated Applicant's son to become involved in treatment himself. As of November 2018, Applicant's son was attending an IOP, reportedly no longer abusing drugs, and employed at a donut shop. (Tr. 38-43.)

On September 9, 2017, Applicant completed and certified to the accuracy of a Questionnaire for National Security Positions (SF 86). Applicant disclosed that he had received mental-health treatment for an estimated eight months in 2008. In response to an inquiry concerning whether he had ever been hospitalized for a mental-health condition, Applicant reported that he had undergone voluntary treatment for five days in July 2016 for alcohol detoxification and for seven days in July 2017 for alcohol detoxification and depression at hospital X. He also responded affirmatively to whether he had misused any prescription drug in the last seven years, but then disclosed that he misused OxyContin and Vicodin from January 2008 to May 2008, more than seven years ago. Applicant answered "Yes" to an inquiry concerning whether his use of alcohol has had a negative impact on his work performance, professional or personal relationships, or finances in the last seven years. He reported that his drinking between March 2015 and May 2015 led him to miss work. He listed three alcohol-related treatments: his outpatient therapy at the clinic in 2015 and voluntary alcohol treatments at hospital X in May 2015 and July 2017. (GE 1.)

At the request of the DOD, Applicant was evaluated on October 8, 2017, by a duly-qualified licensed psychologist. Applicant indicated that he was again living with his son and grandson, who was no longer using drugs and was employed. Applicant discussed

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[6] Applicant's disability benefit ran out after six months (Tr. 47), and he began to rely on credit cards to pay bills. He resolved most of his financial stress by a Chapter 7 bankruptcy discharge granted in October 2017. (AE A; Tr. 89.)

[7] The medical records from this admission were not presented in evidence. Applicant provided a copy of the records to the psychologist, who evaluated him for the DOD in October 2017.

with the psychologist his misuse of opiates obtained from friends and associates in the past to self-medicate for pain. He denied ever using heroin, although he indicated that he voluntarily sought Suboxone treatment because he was concerned that his opiate use would progress to heroin. He reported taking Suboxone for about six years before being discharged for using alcohol. He denied any misuse of opiate pain medication since 2005. Applicant reported experiencing depression and suicide ideation in the past, but only when he was drinking alcohol and facing a number of stressors. He reported that he was taking medications for depression and sleep prescribed during his recent hospitalization in July 2017, but also that he did not see any benefit to the medications and planned to stop taking them. Applicant denied any consumption of alcohol since July 6, 2017, and any desire to drink alcohol. He was attending seven AA meetings per week, working the steps with his sponsor, and felt that AA had saved his life. Applicant expressed confidence that, if he continued working with AA, he would be fine. (GE 2.)

The clinical psychologist assessed Applicant's optimism about his sobriety as "somewhat excessive at this point considering his relapses despite being involved in AA in the past and his relatively short period of sobriety." He diagnosed Applicant with alcohol use disorder, severe, in early remission, and with a history of adjustment disorder with depressed mood. Symptoms of anxiety and depression were only present within the context of Applicant's excessive alcohol use or in the face of significant life stressors. The psychologist considered alcohol abuse a significant concern due to Applicant's long period of difficulties and his repeated relapses. He opined that Applicant's alcohol use disorder, severe, is a condition that would negatively impact his reliability, judgment, stability, and trustworthiness. He noted that Applicant had an appointment to restart addictions counseling, but that Applicant appeared ambivalent about restarting psychotherapy. While Applicant appeared strongly invested in AA, the psychologist recommended that Applicant also have treatment and monitoring by professionals, such as in outpatient psychotherapy. The psychologist gave Applicant a guarded prognosis due to his brief period of sobriety (since July 6, 2017), his repeated relapses in the past, and his lack of recent consistent engagement in treatment. In Applicant's favor, the psychologist cited his lengthy sobriety of some 20 years in the past; his AA involvement with a supportive sponsor; his resolution of a number of stressors by recently filing for bankruptcy and filing a complaint of elder abuse against his son; and his recent outreach for help when needed. The psychologist did not consider Applicant's drug abuse to be a recent or current problem, given that drug screens during recent hospitalizations have been consistently negative. (GE 2.)

Applicant stopped taking his prescribed anti-depressant and sleep medications a couple of months after he regained his sobriety and resumed his affiliation with AA following his July 2017 treatment. He did not feel that he needed them. (Tr. 67.) He also did not keep the appointment for addictions counseling. (Tr. 84.)

Applicant does not allow alcohol or illegal drugs in his home. (Tr. 64, 89.) He has not consumed any alcohol since July 2017 (Tr. 71), and he does not believe that he will relapse if his son relapses. (Tr. 78.) He denies ever reporting to work drunk or ever drinking at work. (Tr. 74.) Available medical records show that he may have been hungover at work in the past (GE 2), but he was never reprimanded. (Tr.73.)

Applicant describes himself as "a recovering—recovered alcoholic." He attributes his past substance abuse to an incorrect diagnosis of a physical condition which resulted in chronic pain that undermined his attempts at sobriety. As of November 2018, Applicant was still attending seven AA meetings a week. Applicant has been an AA sponsor for about ten months as of November 2018. He sponsors four AA attendees in his home group. In March 2018, he started a Saturday night "Big Book" meeting. He supports alcoholics in local sober-house programs by driving several men to area AA meetings multiple times per week. Applicant has attended two weekend retreats and is involved in a group that emphasizes the 12-step recovery program. He has worked all 12 steps of the AA program. He has had his current sponsor since August or September 2017. His sponsor has 12 years of sobriety. (AE A; Tr. 85-99.)

Applicant was not currently in any formal counseling or psychotherapy as of November 2018. (Tr. 88.) He does not believe that he currently needs any psychotherapy and explained that it never worked for him. (Tr. 93.) When asked to explain why he believes AA is now sufficient to guarantee against relapse given his relapse history, which includes relapse after 20 years of sobriety with AA involvement for most of that time, Applicant responded that he was working the steps, sponsoring people, attending meetings, and "doing the work that [he] wasn't doing at the end of that last 20 years." In the past, he got caught up with work and did not think that he needed AA anymore. (Tr. 101-102.)

Applicant's AA sponsor provided a character reference letter attesting to Applicant's initial struggles in recovery from his alcohol problem. He agreed to become Applicant's sponsor without reservations because Applicant demonstrated to him willingness to change his life. He corroborates that Applicant has been very active in his local recovery community by sponsoring others struggling with addiction and by starting a Saturday evening AA meeting attended by 30 to 40 people. In the sponsor's opinion, Applicant has "always been a person with integrity, honesty, and morals as a driving force in his life." The sponsor has "the highest respect" for Applicant. (AE B.)

Policies

The U.S. Supreme Court has recognized the substantial discretion the Executive Branch has in regulating access to information pertaining to national security, emphasizing that "no one has a 'right' to a security clearance." *Department of the Navy v. Egan*, 484 U.S. 518, 528 (1988). When evaluating an applicant's suitability for a security clearance, the administrative judge must consider the adjudicative guidelines. In addition to brief introductory explanations for each guideline, the adjudicative guidelines list potentially disqualifying conditions and mitigating conditions, which are required to be considered in evaluating an applicant's eligibility for access to classified information. These guidelines are not inflexible rules of law. Instead, recognizing the complexities of human behavior, these guidelines are applied in conjunction with the factors listed in the adjudicative process. The administrative judge's overall adjudicative goal is a fair, impartial, and commonsense decision. According to AG ¶ 2(a), the entire process is a conscientious scrutiny of a number of variables known as the "whole-person concept." The administrative

judge must consider all available, reliable information about the person, past and present, favorable and unfavorable, in making a decision.

The protection of the national security is the paramount consideration. AG ¶ 2(b) requires that "[a]ny doubt concerning personnel being considered for national security eligibility will be resolved in favor of the national security." In reaching this decision, I have drawn only those conclusions that are reasonable, logical, and based on the evidence contained in the record. Under Directive ¶ E3.1.14, the Government must present evidence to establish controverted facts alleged in the SOR. Under Directive ¶ E3.1.15, the applicant is responsible for presenting "witnesses and other evidence to rebut, explain, extenuate, or mitigate facts admitted by applicant or proven by Department Counsel. . . ." The applicant has the ultimate burden of persuasion to obtain a favorable security decision.

A person who seeks access to classified information enters into a fiduciary relationship with the Government predicated upon trust and confidence. This relationship transcends normal duty hours and endures throughout off-duty hours. The Government reposes a high degree of trust and confidence in individuals to whom it grants access to classified information. Decisions include, by necessity, consideration of the possible risk that the applicant may deliberately or inadvertently fail to safeguard classified information. Such decisions entail a certain degree of legally permissible extrapolation about potential, rather than actual, risk of compromise of classified information. Section 7 of EO 10865 provides that decisions shall be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant concerned." *See also* EO 12968, Section 3.1(b) (listing multiple prerequisites for access to classified or sensitive information).

Analysis

Guideline G: Alcohol Consumption

The security concern for alcohol consumption is articulated in AG ¶ 21:

> Excessive alcohol consumption often leads to the exercise of questionable judgment or the failure to control impulses, and can raise questions about an individual's reliability and trustworthiness.

Applicant began drinking alcohol when he was only a teenager. After completing an alcohol-rehabilitation program in 1985, he was abstinent from alcohol for about 20 years until 2005. Periodic consumption of alcohol on business trips progressed to weekend drinking of two or three drinks. By 2009, he had lost control over his drinking, as evidenced by his consumption of a pint of alcohol per day preceding his request for alcohol-detoxification in May 2009. Over the next seven to eight years, he continued to abuse alcohol, despite repeated detoxification treatments; participation in counseling, IOP, and PHP; diagnoses of alcohol dependence or alcohol use disorder, severe; and while taking Suboxone against medical advice. Applicant told an OPM investigator in January 2017 that he had stopped drinking in September 2016 with the help of AA. However, the evidence shows that he was not sober when his son brought him to the hospital on October 5, 2016.

Over the month, he abused alcohol, leading to yet additional detoxifications and counseling for his alcohol problem. Applicant maintained sobriety from November 2016 until June 2017, when feeling overwhelmed by life stressors, he consumed a pint of liquor per day for about three weeks. It led to yet another inpatient stay from July 7, 2017, to July 14, 2017, for major depressive disorder, alcohol withdrawal, alcohol dependence, and suicidal ideation.[8] In October 2017, Applicant was evaluated by a duly-qualified licensed clinical psychologist, who opined that Applicant's alcohol abuse disorder, severe (in early remission) is a condition that would negatively impact his reliability, judgment, stability, and trustworthiness.

Applicant's history of maladaptive use of alcohol triggers the following disqualifying conditions under AG ¶ 22:

> (c) habitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed with alcohol use disorder;
>
> (d) diagnosis by a duly qualified medical or mental health professional (e.g., physician, clinical psychologist, psychiatrist, or licensed clinical social worker) of alcohol use disorder;
>
> (e) the failure to follow treatment advice once diagnosed; and
>
> (f) alcohol consumption, which is not in accord with treatment recommendations, after a diagnosis of alcohol use disorder.

Under ¶ E3.1.15 of the Directive, Applicant has the burden to produce evidence to rebut, explain, extenuate, or mitigate the security concerns. AG ¶ 23 provides for mitigation under the following conditions:

> (a) so much time has passed, or the behavior was so infrequent, or it happened under such unusual circumstances that it is unlikely to recur or does not cast doubt on the individual's current reliability, trustworthiness, or good judgment;

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[8] Neither Applicant's abuse of alcohol from June 2017 to July 6, 2017, nor his July 2017 detoxification and IOP counseling were alleged in the SOR, even though they were referenced by the licensed clinical psychologist in his report of his October 2017 evaluation. In ISCR Case No. 03-20327 at 4 (App. Bd. Oct. 26, 2006), the Appeal Board listed five circumstances in which conduct not alleged in an SOR may be considered stating:

> (a) to assess an applicant's credibility; (b) to evaluate an applicant's evidence of extenuation, mitigation, or changed circumstances; (c) to consider whether an applicant has demonstrated successful rehabilitation; (d) to decide whether a particular provision of the Adjudicative Guidelines is applicable; or (e) to provide evidence for whole person analysis under Directive Section 6.3.

Applicant's latest relapse and treatment cannot be considered for disqualifying purposes, but they are relevant to assessing mitigation, including matters in rehabilitation.

> (b) the individual acknowledges his or her pattern of maladaptive alcohol use, provides evidence of actions taken to overcome this problem, and has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations;
>
> (c) the individual is participating in counseling or a treatment program, has no previous history of treatment and relapse, and is making satisfactory progress in a treatment program; and
>
> (d) the individual has successfully completed a treatment program along with any required aftercare, and has demonstrate a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations.

Applicant asserts, and there is no evidence to the contrary, that he has not consumed alcohol since July 6, 2017. His 16 months of continued sobriety as of his November 2018 hearing is viewed favorably. However, given his record of relapses after repeated treatments since 2009, AG ¶ 23(a) cannot reasonably apply.

AG ¶ 23(b) has some applicability, primarily because Applicant has a pattern of seeking alcohol-detoxification treatment when he felt that he had lost control over his drinking. Some concern arises as to whether Applicant fully acknowledges the seriousness of his alcohol problem. He told an OPM investigator in January 2017 that he does not believe he is an alcoholic. At his November 2018 hearing, he described himself as "a recovering—recovered alcoholic," which may be an expression of optimism about his recovery or even more troubling, an attitude of complacency about his recovery. To the extent that he now attributes his serious relapses to a medical misdiagnosis which resulted in the physical pain that undermined his attempts at sobriety, Applicant shows he has yet to fully accept responsibility for his abusive relationship with alcohol.

Applicant has never been disciplined at work because of his drinking, and he has not had any legal difficulties because of his alcohol abuse. AG ¶ 23(c) recognizes that individuals with an alcohol problem are to be encouraged to seek treatment without fear that doing so will cost them their job. Even so, Applicant's pattern of repeated, serious relapses after several inpatient detoxifications and outpatient counseling efforts not only removes AG ¶ 23(c) from consideration, but it makes it difficult to fully mitigate the alcohol consumption security concerns under AG ¶ 23(d).

Medical record evidence shows that Applicant was successfully detoxified from alcohol in May 2009. He appeared motivated to cease his abuse when discharged to a PHP, and yet he continued to drink alcohol. By January 2015, he was consuming ten shots of liquor per day while on antagonist therapy (Suboxone) knowing that he had been advised by his psychiatrist to abstain from alcohol. During another detoxification stay in June 2015, Applicant reported he was attending AA. He falsely claimed during counseling from September 2015 to May 2016 that he was abstinent from alcohol. Applicant drank repeatedly to intoxication in July 2016, which resulted in visits to his local emergency

department and another detoxification at hospital X. He consumed ten or more alcohol drinks per day after his psychiatrist terminated his Suboxone for drinking alcohol, culminating in another inpatient admission for alcohol detoxification in September 2016. Despite attending AA after his discharge, he was unable to stop drinking. He was intoxicated when transported to his local hospital by ambulance on October 5, 2016. After yet another detoxification, he expressed remorse about his drinking to staff when readmitted to his IOP on October 11, 2016. Within days, he was already drinking heavily. Following an uncomplicated alcohol detoxification at another hospital from October 19, 2016, to October 25, 2016, Applicant still struggled to accept responsibility for his sobriety, as evidenced by his consumption of seven to nine alcohol drinks per day for the five days preceding yet another emergency department visit on October 31, 2016.

Applicant was sober during his five days in a PHP in November 2016 and when receiving counseling in his IOP from November 9, 2016, through November 23, 2016. Applicant's therapist noted that AA was Applicant's primary source of sobriety. After the IOP, Applicant followed up with addictions counseling, which he maintains he completed in June 2017. Surgery in January 2017 alleviated the chronic pain that he submits was a factor in his inability to remain sober. However, financial stress and problems with his son then led to a serious relapse in June 2017. For about three weeks, he consumed about a pint of alcohol per day. During his latest inpatient detoxification from July 7, 2017, to July 14, 2017, he was again diagnosed with alcohol dependence. Applicant participated in aftercare in the IOP three nights a week for five weeks, and he continues to attend AA on a daily basis. However, a duly-qualified psychologist gave Applicant a guarded prognosis in October 2017 because of his relapse history. The psychologist recommended that Applicant not only continue in AA, but that he also obtain professional counseling. Applicant did not keep the appointment that he had scheduled for addictions counseling because he believes AA is enough to maintain his sobriety.

Applicant's commitment to AA includes attending seven meetings per week, working with his sponsor, providing other AA attendees transportation to meetings, starting a Saturday night meeting, and being a sponsor himself. Applicant's sponsor indicates that Applicant is intensively working his own program and is committed to putting his struggles behind him. While I have no reason to doubt Applicant's current dedication to AA, he is not presently engaged in treatment with any medical professional or qualified substance abuse clinician that could assist him to avoid alcohol should he face stressful circumstances in the future. For the reasons noted, the alcohol consumption security concerns are not fully mitigated.

Guideline H: Drug Involvement and Substance Misuse

The security concerns about drug involvement and substance misuse are articulated in AG ¶ 24:

> The illegal use of controlled substances, to include the misuse of prescription and non-prescription drugs, and the use of other substances that cause physical or mental impairment or are used in a manner inconsistent with their

> intended purpose can raise questions about an individual's reliability and trustworthiness, both because such behavior may lead to physical or psychological impairment and because it raises questions about a person's ability or willingness to comply with laws, rules, and regulations. *Controlled substance* means any "controlled substance" as defined in 21 U.S.C. 802. Substance misuse is the generic term adopted in this guideline to describe any of the behaviors listed above.

The evidentiary record establishes that Applicant illegally obtained and used Vicodin or Percocet and OxyContin from May 2007 to May 2009, while he held a DOD secret clearance. Although he denied ever using heroin when he answered the SOR allegations, he acknowledged at his hearing that he used heroin a few times when he could not obtain OxyContin, including twice on the weekend before his treatment for diagnosed alcohol dependence, opioid abuse, and alcohol intoxication in May 2009. On his admission for detoxification treatment in 2009, Applicant reported to clinicians that he had used "half a bundle of heroin per day" at times, although he now maintains that he said that only to ensure that he would be accepted for Suboxone treatment. Applicant has variously claimed that he did not have to pay for the drugs that he obtained illegally from friends and acquaintances, and that he spent $5,000 to $6,000 for the drugs between 2007 and 2009.

The SOR alleges that Applicant was treated for diagnosed opioid dependence by his psychiatrist from 2012 to November 2016, and for diagnosed opioid use disorder, severe, in early remission in December 2016. Available medical records show that Applicant was treated with Suboxone from 2009 to approximately August 2016, when his psychiatrist terminated him from his Suboxone after she learned he had been using alcohol while taking the drug against her advice. There is no evidence that he misused his prescription for Suboxone. To the extent that he failed to follow his psychiatrist's advice regarding combining Suboxone with alcohol, it reflects the seriousness of his alcohol problem rather than illegal drug involvement. Regarding the December 2016 diagnosis of opioid use disorder, severe, in early remission, the diagnosis was based on the fact that he had been off the Suboxone maintenance for months.

The following disqualifying conditions under AG ¶ 25 apply:

> (a) any substance abuse;
>
> (c) illegal possession of a controlled substance, including cultivation, processing, manufacture, purchase, sale, or distribution; or possession of drug paraphernalia;
>
> (d) diagnosis by a duly qualified medical or mental health professional (e.g., physician, clinical psychologist, psychiatrist, or licensed clinical social worker) of substance use disorder; and
>
> (f) any illegal use while granted access to classified information or holding a sensitive position.

None of the medical records reflect any illegal use of any drugs by Applicant since he was placed on Suboxone following his 2009 inpatient detoxification. While there is a discrepancy between what he reported to the clinical psychologist who evaluated him in October 2017 (that he had not used any drugs illegally since 2005) and what is shown in the medical records (illegal use to May 18, 2009), a substantial period has passed without recurrence. Some concern arises because Applicant attributes his termination from the Suboxone program for his serious alcohol relapse in October 2016. His psychiatrist noted in August 2017 that he needed Suboxone to prevent withdrawal and relapse into opioid dependence. He had withdrawal symptoms, but they led him to abuse alcohol, which is his primary substance abuse disorder. It is noteworthy that Applicant testified that he was prescribed painkillers after his January 2017 surgery, and that he did not abuse them. His son's abuse of cocaine and heroin in 2017 did not lead him to use illegal drugs. All drug screens that Applicant took during his detoxification and counseling programs were negative for illegal drug use. Applicant was not given a diagnosis of opiate or opiate dependence by a duly-qualified psychologist in October 2017.

Two mitigating conditions under AG ¶ 26 are established because of the passage of some nine years since his illegal drug abuse without any evidence of recurrence. They are as follows:

> (a) the behavior happened so long ago, was so infrequent, or happened under such circumstances that it is unlikely to recur or does not cast doubt on the individual's current reliability, trustworthiness, or good judgment; and
>
> (b) the individual acknowledges his or her drug involvement and substance misuse, provides evidence of actions taken to overcome this problem, and has established a pattern of abstinence, including but not limited to:
>
> (1) disassociation from drug-using associates and contacts;
>
> (2) changing or avoiding the environment where drugs were used; and
>
> (3) providing a signed statement of intent to abstain from all drug involvement and substance misuse, acknowledging that any future involvement or misuse is grounds for revocation of national security eligibility.

Applicant's illegal use of prescription narcotics and opiates, and of the illegal drug heroin while he held a security clearance is certainly not condoned. Should Applicant relapse while in AA, it is likely to be alcohol and not opiates. The drug involvement and substance misuse security concerns are mitigated.

Guideline I: Psychological Conditions

The security concerns about psychological conditions are articulated in AG ¶ 27:

> Certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness. A formal diagnosis of a disorder is not required for there to be a concern under this guideline. A duly qualified mental health professional (e.g. clinical psychologist or psychiatrist) employed by, or acceptable and approved by the U.S. Government, should be consulted when evaluating potentially disqualifying and mitigating information under this guideline and an opinion, including prognosis, should be sought. No negative inference concerning the standards in this guideline may be raised solely on the basis of mental health counseling.

Applicant has a history of depression for which he was first placed on a mood stabilizer (Cymbalta) while in counseling from September 2015 to July 2016. During a medication management session with his then treating psychiatrist in early August 2016, Applicant exhibited moderate symptoms of anxiety and depression. When his psychiatrist terminated her relationship with him because he drank alcohol while taking Suboxone against clinical advice, the psychiatrist recommended that he seek counseling for his diagnosed major depressive disorder. Applicant exhibited symptoms of anxiety and depression while being safely detoxed from alcohol in September 2016. At discharge, he was diagnosed, in part, with unspecified anxiety disorder and unspecified depressive disorder. Applicant expressed some suicidal thoughts when intoxicated in October 2016, and during his inpatient detoxification in mid-October, he was diagnosed, in part, with depressive disorder, unspecified. He was prescribed an anti-depressant at discharge. Six days later, he was brought to his hospital emergency department after he had expressed fear that he might kill himself, although he was considered safe for discharge the next day following a mental-health assessment.

During IOP counseling in November 2016, Applicant exhibited heightened anxiety because of tight finances. When discharged from the IOP on November 23, 2016, he was diagnosed, in part, with unspecified anxiety disorder and unspecified disorder (provisional), which suggests that clinicians were not certain whether he met the diagnostic criteria for the depressive disorder. Applicant denied any significant symptoms of anxiety or depression during an intake evaluation for addictions counseling in December 2016. Following his relapse into drinking in June 2017, Applicant received inpatient treatment for, in part, diagnosed major depressive disorder and suicidal ideation.

Despite a history of mental-health concerns, the psychological conditions disqualifying conditions have minimal applicability. Applicant's expressed suicidal ideation is not sufficient to trigger AG ¶ 28(a), given he denies that he had any intention to kill himself; he was drunk when he expressed suicidal ideation; and he took no action to harm himself. AG ¶ 28(a) provides:

> (a) behavior that casts doubt on an individual's judgment, stability, reliability, or trustworthiness, not covered under any other guideline and that may indicate an emotional, mental, or personality condition, including, but not limited to, irresponsible, violent, self-harm, suicidal, paranoid, manipulative, impulsive, chronic lying, deceitful, exploitative, or bizarre behavior.

Regarding AG ¶ 28(b), "an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness," Applicant believes his depression was a product of his heavy drinking. Applicant exhibited no overt signs of depression, anxiety, or other mental health condition during his October 2017 evaluation. The psychologist diagnosed him with a history of adjustment disorder with depressed mood, but also opined that Applicant's depressive symptoms and anxiety were only present in the context of his excessive alcohol use and/or in the face of significant life stressors. The psychologist did not find that Applicant's depression was currently problematic with regard to causing impaired judgment, reliability, or trustworthiness.

AG ¶ 28(c), "voluntary or involuntary inpatient hospitalization," has some applicability because Applicant's mental health was of concern during his inpatient treatments in October 2016, November 2016, and July 2017. Even so, his inpatient treatments and counseling programs were primary for alcohol detoxification and not for psychological reasons. To the extent that AG ¶ 28(c) is triggered, three mitigating conditions apply under AG ¶ 29. They are:

> (c) recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by, the U.S. Government that an individual's previous condition is under control or in remission, and has a low probability of recurrence or exacerbation;
>
> (d) the past psychological/psychiatric condition was temporary, the situation has been resolved, and the individual no longer shows indications of emotional instability; and
>
> (e) there is no indication of a current problem.

Available medical records and the recent opinion of a duly-qualified psychologist, who is recognized by the DOD to provide sound, professional assessments of mental-health conditions, substantiate that Applicant's primary issue has been his alcohol abuse disorder. The psychological conditions are not of current security concern.

Whole-Person Concept

Under the whole-person concept, the administrative judge must evaluate an applicant's eligibility for a security clearance by considering the totality of his conduct and all relevant circumstances in light of the nine adjudicative process factors listed at AG ¶

2(d).[9] In making the overall commonsense determination required under AG ¶ 2(a), there is no evidence that Applicant ever allowed his abuse of alcohol to negatively affect his work performance, although there were times when he could not report to work because of his drinking.

Even so, the Appeal Board has repeatedly held that the government need not wait until an applicant mishandles or fails to safeguard classified information before denying or revoking security clearance eligibility. *See*, *e.g.*, ISCR Case No. 08-09918 (App. Bd. Oct. 29, 2009) (citing *Adams v. Laird*, 420 F.2d 230, 238-239 (D.C. Cir. 1969)). It is well settled that once a concern arises regarding an applicant's security clearance eligibility, there is a strong presumption against the grant or renewal of a security clearance. *See Dorfmont v. Brown*, 913 F. 2d 1399, 1401 (9th Cir. 1990). At some future date, Applicant may be able to show reform for a sufficiently sustained period to safely conclude that his maladaptive use of alcohol is safely in the past. For the reasons discussed, it would be premature to continue Applicant's security clearance eligibility at this time.

Formal Findings

Formal findings for or against Applicant on the allegations set forth in the amended SOR, as required by section E3.1.25 of Enclosure 3 of the Directive, are:

Paragraph 1, Guideline G:	AGAINST APPLICANT
Subparagraphs 1.a-1.i:	Against Applicant
Paragraph 2, Guideline H:	FOR APPLICANT
Subparagraph 2.a:	For Applicant
Paragraph 3, Guideline I:	FOR APPLICANT
Subparagraph 3.a:	For Applicant
Paragraph 4, Guideline F:	WITHDRAWN
Subparagraph 4.a:	Withdrawn

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[9] The factors under AG ¶ 2(d) are as follows:

> (1) the nature, extent, and seriousness of the conduct; (2) the circumstances surrounding the conduct, to include knowledgeable participation; (3) the frequency and recency of the conduct; (4) the individual's age and maturity at the time of the conduct; (5) the extent to which participation is voluntary; (6) the presence or absence of rehabilitation and other permanent behavioral changes; (7) the motivation for the conduct; (8) the potential for pressure, coercion, exploitation, or duress; and (9) the likelihood of continuation or recurrence.

Conclusion

In light of all of the circumstances, it is not clearly consistent with the national interest to continue Applicant's eligibility for a security clearance. Eligibility for access to classified information is denied.

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Elizabeth M. Matchinski
Administrative Judge