DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 09-00318
	)	
	)	
Applicant for Security Clearance	)	

Appearances

For Government: Eric H. Borgstrom, Esquire, Department Counsel
For Applicant: *Pro se*

06/14/2012

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Decision

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MATCHINSKI, Elizabeth M., Administrative Judge:

Applicant has a long history of noncompliance with the treatment protocol for his diagnosed bipolar disorder, resulting in impairment of his judgment and in dysfunctional behavior requiring hospitalization. He abused marijuana from about 1983 to November 2010, including since 2002 with a Department of Defense security clearance. He also drank alcohol to at least 2007, knowing it could impair the effectiveness of his psychiatric medications. Clearance denied.

Statement of the Case

On February 8, 2012, the Defense Office of Hearings and Appeals (DOHA) issued a Statement of Reasons (SOR) to Applicant, detailing the security concerns under Guideline I (Psychological Conditions), Guideline G (Alcohol Consumption), Guideline H (Drug Involvement), and Guideline E (Personal Conduct) as to why it could not find that it is clearly consistent with the national interest to continue Applicant's security clearance eligibility. DOHA took action under Executive Order 10865, *Safeguarding Classified Information within Industry* (February 20, 1960), as amended; Department of Defense Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program*

(January 2, 1992), as amended (Directive); and the adjudicative guidelines (AG) effective within the Department of Defense on September 1, 2006.

Applicant submitted an undated answer, in which he responded to the SOR allegations and requested a hearing. On May 3, 2012, the case was assigned to me to consider whether it is clearly consistent with the national interest to grant or continue a security clearance for him. On May 16, 2012, I scheduled a hearing for June 6, 2012.

The hearing was convened as scheduled. Twenty-nine Government exhibits (GEs 1-29) were admitted into evidence. GEs 16 and 17 were admitted over Applicant's objection about the psychiatric medications reported in the medical records, and with respect to GE 17, also about the accuracy of the report of the incident that led to his hospitalization. GE 28 was admitted over Applicant's objection to the accuracy of the treatment dates and diagnoses reported by the provider. GE 29 was objected to on the basis of an incomplete listing of his psychiatric medications. His objections went to the weight of the information rather than its admissibility. Thirteen Applicant exhibits (AEs A-M) were admitted into evidence without objection. Applicant and his spouse testified, as reflected in a transcript (Tr.) received by DOHA on June 14, 2012.

I held the record open for one week after the hearing for Applicant to submit character reference letters. On June 14, 2012, I granted a brief extension at Applicant's request. On June 18, 2012, I received six letters, which were marked collectively as AE N. Department Counsel did not object, and the exhibit was admitted.

Summary of SOR Allegations

The SOR alleged under Guideline I that Applicant failed to take medications prescribed for his mental health condition at times between 1996 and 2008, resulting in an impairment of his judgment and in dysfunctional behavior requiring hospitalization (SOR 1.a). Under Guideline G, Applicant allegedly consumed alcohol, at times to excess, from 1996 to at least 2007, aware that alcohol could have an adverse effect on his treatment and mental health, and that his drinking resulted, at times, in hallucinations and uncontrolled behavior requiring hospitalization (SOR 2.a). Applicant was alleged under Guideline H to have abused marijuana and PCP in 2007 and 2008, knowing that use of other drugs could have an adverse effect on his treatment and his mental health, and resulting in hallucinations and uncontrolled behavior requiring periodic hospitalization (SOR 3.a); to have continued to use marijuana in 2010 (SOR 3.b); and to have used marijuana and PCP while possessing a security clearance from about 2002 to at least 2010 (SOR 3.c). The Guideline G and Guideline H allegations were also alleged to raise Guideline E concerns (SOR 4.a).

Applicant admitted the allegations, except for any knowing abuse of PCP. He attributed his "PCP exposure" to cough medicine ingested for chest congestion. Also, Applicant explained that his previous psychiatric medications (Risperdal and Depakote) had unpleasant side effects and had not been completely effective in managing his mental illness. A change in his medications to Lamictal and Invega gradually brought about "a

normalcy [he] had not felt before." Applicant also indicated that he realizes that "the national interest is best served by an intolerance for substance abuse and [he intends his] actions to fully reflect that interest."

Findings of Fact

Applicant's admissions are incorporated as findings of fact. After considering the pleadings, exhibits, and transcript, I make the following additional findings of fact.

Applicant is a 51-year-old machine operator, who has worked for the same defense contractor since August 1984, initially as a machinist and then as a toolmaker. (GE 3; Tr. 208.) Applicant seeks to retain a secret security clearance, which was granted to him in March 2002. (GEs 1, 2; Tr. 86.)

Applicant married his present wife in September 2004. Applicant has a son, who is now 23 years old, with whom he has smoked marijuana. Applicant has no contact with his first wife, to whom he was married from May 1981 to January 1986. (GEs 1, 2.)

Applicant served on active duty in the United States military from 1979 to 1983. (Tr. 85.) While in the active reserves from 1983 to 1985, Applicant began using marijuana sporadically. After he began working for his current employer in 1984, Applicant smoked marijuana two or three times a month on the weekends. (Tr. 93-94.) He continued to use the drug with varying frequency until November 2010, abstaining "numerous times." (Tr. 95.) His longest abstention was for about six months in 2001 and 2002, after he applied for his secret clearance. (Tr. 95.) Applicant purchased marijuana on occasion, and his son also bought marijuana for him with money Applicant provided. (Tr. 96-97.)

Applicant has been under the care of a succession of mental health providers for diagnosed bipolar disorder since 1992. (Tr. 87-88.) Treatment, including prescribed psychiatric medications, has had varied success in managing his mental health condition, in part because Applicant has not always followed therapeutic advice. Salient details of his mental health condition and treatments, including the effects of his noncompliance with treatment protocol, follow.

In 1990, Applicant was treated at a psychiatric hospital (psychiatric facility A), and he had outpatient counseling at a local hospital. In September 1992, Applicant was arrested for disturbing the peace. He and his then girlfriend (his son's mother) had broken off their relationship, and he confronted her at church services before a member of the congregation tackled him. The police took him to a local emergency room because he was confused. Applicant was transferred to a psychiatric hospital (psychiatric facility B). (GE 4.) The medical records of this hospitalization, or of his treatment with a private physician from October 1992 to February 1993, were not made available for my review. The criminal charge was dismissed. (GEs 3, 4.)

From February 1993 to December 1999, Applicant was under the active care of the same psychiatrist. (GE 3.) Between 1992 and 1996, Applicant went off his medication at

times due to confusion or lack of routine (i.e., missed doses). (Tr. 89-90.) Around 1994, Applicant began stopping once a week at a local bar on his way home from work and drinking a couple of 16-ounce beers. (GE 5.) Around July 1, 1996, Applicant stopped taking his Depakote medication for his bipolar disorder. He drank alcohol while on vacation, knowing that it could interfere with his psychiatric medications. (Tr. 92.) He did not sleep over the next few days. En route home from vacation, Applicant stopped at a motel with his spouse (then girlfriend) and his son. He became violent after arguing with his girlfriend, and the police arrived to find him "smashing up" his motel room.[1] Applicant was combative with the police, and he was arrested for aggravated assault and disturbing the peace.[2] (GEs 3, 17; Tr. 91, 124-30.) The police brought Applicant to a local emergency room because he was agitated and incoherent. Applicant was diagnosed with psychotic disorder, not otherwise specified, and he was prescribed antipsychotic and tranquilizer medications before being transferred to a psychiatric hospital (psychiatric facility C). (GEs 4, 16.)

Applicant was treated at psychiatric facility C from July 5-11, 1996, for bipolar disorder, manic with psychotic features, and for alcohol abuse-episodic. On admission, he was cooperative and showed no signs of agitation, although his insight and judgment were poor. He was placed on Trilafon and Depakote, which he took with no problem. Applicant reported previous hospitalizations for his bipolar disorder; treatment with Trilafon, Depakote, and Lithium in the past;[3] a long history of erratic compliance with his medications; and consumption of beer. His condition was considered sufficiently stable to discharge him with a good prognosis. He was advised to follow up with his private psychiatrist and to take his Trilafon and Depakote medications as prescribed. (GE 17.)

On February 22, 2000, Applicant completed a security clearance application (SF 86). He disclosed his arrest in 1996 and his psychiatric counseling since October 1992. Applicant did not report his treatment at psychiatric facility C in 1996. He also responded "No" to whether he had illegally used any controlled substance, including marijuana, in the last seven years. (GE 3.) During an interview with a Defense Investigative Service (DIS) special agent on June 27, 2000, Applicant admitted that he had been hospitalized for mental health treatment in 1990, 1992, and 1996. Concerning his behavior that led to his involuntary commitment in 1996, Applicant recalled that he had stopped taking his medication a few days before the incident, and he was "in a confused mental state" that led him to resist police. He disclosed a 1986 drunk-driving offense. There is no indication whether illegal drug use was discussed. (GE 4.)

[1]Applicant attributes his "difficulties" on that occasion to primarily fatigue (driving too long without stopping to rest). (Tr. 74.)

[2] Applicant was later assessed a $2,000 fine and ordered to pay restitution on the criminal charges. (GEs 3, 4.)

[3]Applicant denies that he took any Lithium. (Tr. 26.) Emergency medical personnel listed Applicant's medications as Depakote and Lithium in July 1996. (GE 16.) Applicant has a history of medication changes. He could have been on Lithium until 1996. He testified he was on an antidepressant, although he cannot recall which one. (Tr. 89.) Alternatively, but less likely, Applicant may have told them he was on an antidepressant that was presumed to be Lithium. In any event, there is no evidence that Applicant has been prescribed Lithium since 1996.

Between June 2001 and September 2001, Applicant received alcohol-related treatment. (GE 2.) On October 3, 2001, Applicant was re-interviewed by the DIS special agent to update his mental health situation. Applicant was continuing to see his psychiatrist, on a monthly basis for the past three months, due to changes in his medication. Applicant reported no new hospitalization or legal incidents. Applicant denied that he had a problem with alcohol. He indicated that between November 1999 and September 2000, his sister and her two young daughters lived with him. He drank four or five 12-ounce beers at bars after work while waiting to return home until after his nieces quieted down. Applicant denied becoming intoxicated, but he admitted that the alcohol reduced the effectiveness of one of his psychiatric medications. Applicant stopped frequenting bars after his sister moved out. He indicated that he now drinks a lemon flavored malt liquor in responsible quantity, and he is "always aware of the interaction between the alcohol and [his] medications." Applicant planned to drink occasionally unless or until his psychiatrist told him to stop due to his psychiatric medications. (GE 5.)

In February 2002, DOHA asked Applicant to undergo a substance abuse evaluation by a professional of his choice. On February 15, 2002, Applicant was evaluated by a PhD and LCSW-credentialed senior clinician affiliated with a substance abuse treatment facility. Applicant exhibited no gross disturbances to the content or character of his thought. In the opinion of the clinician, Applicant "exhibited insight into the relationship of his past drinking and the stressors in his life as well as the need and the willingness to be compliant with his medication in order to function in an acceptable manner both at work and at home." Applicant acknowledged that he had continued to drink alcohol, but he resolved to stop if drinking would jeopardize his job. The substance abuse professional found no current evidence of alcohol dependence or alcohol abuse ("At this time, a more accurate description of his past episodes appears to be Alcoholic Abuse (DSM-IV CPT 305.00))." (GE 6.)

On March 6, 2002, Applicant told DOHA that he believed his 1996 arrest and involuntary commitment to psychiatric facility C were due to alcohol interacting with his medications. Realizing that "unacceptable behavior" could result from the interaction of alcohol and his medications, Applicant indicated that he had chosen to stop drinking. (GE 6.) Applicant's secret clearance was issued to him in March 2002. (GE 2.)

In December 2002, Applicant started a therapeutic relationship (antipsychotic medications and supportive psychotherapy) with a new psychiatrist for treatment of diagnosed manic depressive disorder and alcoholism. While under the care of this psychiatrist, Applicant did well when he took his medications, but he had "a few setbacks," in part because he went off his prescribed medications (i.e., Risperdal and Depakote[4]).

[4]Applicant submitted information concerning recommended dosages, contraindications, drug interactions, and potential adverse reactions for psychiatric medications he has taken for his bipolar disorder: Risperdal (risperidone), an antipsychotic indicated for the short-term treatment of acute manic episodes in bipolar patients (AE H); Depakote, a valprobate anti-epileptic indicated for treatment of manic episodes associated with bipolar disorder (AE I); Effexor XR (venlafaxine) (AE J) and Wellbutrin (bupropion) (AE K), antidepressants indicated for treatment of a major depressive disorder, but apparently not approved for use in treating bipolar depression; Invega (palipridone, the major active metabolite of risperidone), an atypical antipsychotic for treatment of schizophrenia (AE L), and Lamictal, an anti-epileptic indicated for maintenance

(GE 28.) In April 2004, Applicant was found disoriented at his workplace several hours after his shift had ended. He was transported by ambulance to a local hospital, where he was placed on a medical hold. Applicant advised emergency staff that he suffered from bipolar disorder, but he had not taken his Depakote medication. Applicant was diagnosed with psychosis, not otherwise specified, and bipolar disorder with manic episode. The next afternoon, Applicant was transferred to psychiatric facility A. (GE 18.) The records of this admission to psychiatric facility A were not available for my review.

On February 7, 2006, Applicant completed a security clearance application (SF 86). He listed his ongoing mental health counseling with a psychiatrist as well as his psychiatric admissions in 2004. Applicant disclosed that he received alcohol treatment in 2001 "at the request of DOD," and he maintained that he continued to exclude alcohol from his diet. Applicant responded "No" to whether he had used any illegal drugs in the last seven years and to whether he had ever used an illegal drug while holding a security clearance (GE 2), knowing that he should have reported his marijuana use on his SF 86. (Tr. 100.)

In mid-July 2006, Applicant was taken off Depakote and prescribed Lamictal due to weight gain. (AE F; Tr. 69.) By March 2007, Applicant was again experiencing some mental instability, which he attributed to work stress. On March 7, 2007, local law enforcement was called to a gas station after Applicant was observed yelling profanities and wielding a hammer. (GEs 13, 19, 20.) Applicant was arrested for use and possession of drug paraphernalia and possession of marijuana after a wooden pipe and marijuana were found on his person. (GEs 7, 13.) Applicant was also charged with breach of peace, 2nd degree. (GEs 13-15.) The police report indicates that Applicant was cooperative throughout booking at police headquarters and that he was released on a promise to appear. (GE 13.) However, medical records show that Applicant was brought to a local hospital's emergency room on a police hold at around 12:14 p.m. At the hospital, Applicant initially denied any illegal drug use, although he told nursing service that he smoked marijuana twice weekly, and a toxicology screen was positive for THC. (GE 19.) Applicant was transferred to psychiatric facility A, where he was admitted for treatment of diagnosed bipolar disorder, hypomanic. He exhibited abnormal behaviors initially, but his condition stabilized over the next five days. He acknowledged that he was using marijuana on a "somewhat frequent basis" and alcohol occasionally. Applicant was discharged on March 12, 2007, on Effexor, Tileptal, Lisinopril, Simvastatin, Risperdal, and Lamictal medications and with instructions to follow up with his private psychiatrist. His prognosis was noted as "chronic course." (GE 20.)

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treatment of bipolar disorder (AE M). The drug literature specifically cautions against the use of alcohol when taking Risperdal or Invega. Consumption of minimal amounts of alcohol is not specifically contraindicated while taking Wellbutrin or Effexor, although patients should be advised to avoid alcohol while taking Effexor. Alcohol use while taking Lamictal or Depakote is not contraindicated, but patients are advised to not drink while taking Depakote without first discussing it with their health care provider. Medication guidance for Depakote repeatedly warns against stopping the medication without first talking to a health care provider since sudden cessation can cause serious health problems. Furthermore, FDA-approved labeling indicates that the safety and effectiveness of Depakote for long-term use (more than three weeks) has not been systematically evaluated in controlled clinical trials. Healthcare providers who prescribe Depakote for extended periods are advised to continually reevaluate the long-term usefulness of the drug. (AE I.)

Around 2007, Applicant's son came to live with him and his spouse. Applicant's spouse was aware that Applicant was using marijuana with a friend outside of her presence although she disapproved. Before his son moved into their home, Applicant's spouse told Applicant that he had to set a good example and stop abusing marijuana. (Tr. 140-41.)

In December 2007, Applicant was brought to the emergency room after his spouse contacted 911 complaining that he was threatening and potentially violent. Applicant's spouse told the police that she believed Applicant had been drinking alcohol in their basement because she found empty alcohol bottles there. He was also noncompliant with his psychiatric medications. (GEs 21, 22.) Applicant appeared psychotic and disorganized ("talking nonsense") at the hospital. He reported sleep disturbance, mood swings, and auditory hallucinations, despite a medication regimen of several psychiatric medications, including Lamictal and Wellbutrin. (AE F.) Applicant admitted using marijuana and alcohol socially. He was diagnosed with bipolar disorder (acute decompensation—hypomanic) and prescribed Haldol and Ativan before being transferred to psychiatric facility A. (GE 21.)

Applicant was an inpatient at psychiatric facility A for nine days in December 2007. On admission, Applicant presented as "floridly psychotic." He was diagnosed with bipolar disorder, mixed, severe; alcohol abuse; and marijuana abuse. Applicant denied drinking. A urine sample was positive for marijuana and PCP. He was continued on his current medications, but the dosage of Risperdal was increased while on the unit. At discharge, it was noted that he remained mildly psychotic, although not agitated or threatening. He was prescribed Risperdal, Lisinopril, Wellbutrin, Effexor XR, and Lamictal and directed to follow up with his private psychiatrist. A staff psychiatrist gave him a guarded prognosis. (GE 22.)

In January 2008, Applicant pled guilty to the March 2007 possession of marijuana charge. He was fined $85 plus $15 costs and assessed a $205 community service fee, which he paid in lieu of completing community service. The other charges were not prosecuted. (GEs 14, 15.)

Applicant was on leave from work due to stress for about four months. He returned to work in February 2008, reportedly under less stressful conditions. He had been taken off Risperdal in favor of Invega in late January 2008. (AE F.) In early April 2008, Applicant stopped taking his Lamictal after his supply ran out. (GE 25.) He had another episode of psychosis in April 2008 of sufficient concern to his family to contact the police. He was brought to a hospital emergency room on April 13, 2008, where he was evaluated by a licensed clinical social worker (LCSW) affiliated with a mental health center. The LCSW certified Applicant for psychiatric admission under a "gravely disabled" category. Applicant was admitted to the hospital for observation until a bed became available at a mental health treatment facility. On April 14, 2008, a different LCSW evaluated Applicant, and she too certified him for emergency commitment to the first available acute-care psychiatric bed. (GE 24.) A toxicology screen of April 14, 2008, was positive for PCP and marijuana. (GE 23.) Applicant admitted he smoked marijuana daily, but that the PCP ingestion was "probably accidental," possibly due to his marijuana being laced or to using cough syrup a couple of days before. (GEs 23, 24.) Applicant denied any alcohol use. (GE 23.) Applicant

attributes his decompensation to "a matter of the Invega working against the Risperdal" in his system. (Tr. 106.)

From April 16, 2008, to April 18, 2008, Applicant was an inpatient at psychiatric facility D, where he was diagnosed on admission with bipolar disorder with psychotic features, cannabis dependence, and hallucinogen abuse. Applicant was discharged on Effexor XR, Wellbutrin, Lamictal, and Invega medications, to follow up with his private psychiatrist for treatment of diagnosed bipolar disorder, not otherwise specified. (GE 25.)

On September 5, 2008, Applicant completed an Electronic Questionnaire for Investigations Processing (e-QIP). Applicant disclosed his counseling with private psychiatrists since 1993 and his mental health hospitalizations in April 2008, March 2007, and April 2004. He added that he was continuing to abstain from alcohol. Concerning his arrest record, Applicant reported his arrest on drug charges and for breach of peace in March 2007, for which he was fined $100 and ordered to complete drug education classes; a charge of violating a no-contact order in November 2002, which was dismissed, and an October 1986 driving while intoxicated charge, also dismissed. Regarding any illegal drug involvement in the last seven years, Applicant indicated that he used marijuana approximately 20 times while possessing a security clearance from February 2007 to December 2007. (GE 1.) Applicant intentionally did not disclose the full extent of his marijuana use. (Tr. 100.)

On October 28, 2008, Applicant was interviewed by an authorized investigator for the Office of Personnel Management (OPM) about his drug arrest in March 2007 and his use of marijuana. Applicant reported that he appeared in court around May 2007 and pled guilty to one of the three charges. He claimed he could not recall which charge. Concerning his illegal drug use, Applicant told the investigator he smoked marijuana from February 2007 to December 2007 about 20 times, alone or with his son, who purchased the drug at least once with money he provided. Applicant claimed that he tried marijuana as an experiment, but decided it was not something that he wanted to continue. He denied any current abuse of illegal drugs or any intent to use them in the future. Applicant admitted that he used the marijuana while he held a DOD secret clearance, although he denied any adverse impact on his ability to maintain that clearance. Applicant denied any association with anyone who continues to use illegal drugs, but for his son. Applicant claimed he was attempting to convince his son to stop using marijuana. Applicant denied he had ever had a positive drug screen. On March 30, 2009, Applicant affirmed that his account to the OPM investigator about his marijuana use was accurate. (GE 7.)

In June 2009, Applicant began treatment with a new psychiatrist. His former psychiatrist was placed on probation from September 15, 2009, to December 31, 2009, on a complaint of negligence, and he was not to renew his license to practice medicine after December 31, 2009. (AE E.) So, Applicant's insurer was no longer willing to cover his treatment with this psychiatrist. (Tr. 76.) Applicant's new psychiatrist, a doctor of osteopathy, continued to monitor and adjust the dosages of Applicant's medications as needed. (GEs 8, 26; AE F.) In 2010, Applicant informed this psychiatrist that he was using marijuana to self-medicate to overcome some of the side effects of his psychiatric

medications. The psychiatrist advised him to abstain from using illegal drugs, and he instituted urinalysis testing around July 2010 "to force [Applicant] to answer to [himself]." (Tr. 80-81.) A drug screen of July 30, 2010, detected the presence of cannabis, although not within a reportable range. Applicant submitted to four more tests over the next two months, and no drugs were detected. (GE 26.)

On June 28, 2010, Applicant detailed his involvement with illegal drugs at the request of DOHA. Concerning marijuana, he reported use three to four times a month from 1984 to 1990; once to twice a day "with periods of discontinuance" from 1990 to April 2007; and five times a week or less from April 2007 to April 2010. Applicant also disclosed use of mescaline once in July 1989 and possible use of PCP once in April 2008. His illegal drug use caused loose associations among other effects. Applicant added that he sought professional treatment to help him with his commitment to stay drug free. He expressed his hope that his "dishonesty, bad judgment, and procrastination has not cost [him] a satisfying job." (GE 9.)

On June 29, 2010, Applicant began counseling on a weekly basis with a licensed chemical dependency professional (LCDP) for substance abuse and mental health issues. Applicant relapsed into using marijuana in October 2010, which he attributed to extreme anxiety over a family issue. (GEs 10, 27; AE A.) Applicant told his treating LCDP that he relapsed during the week of October 14-21, 2010. She assessed his prognosis as excellent as of mid-December 2010. In her opinion, Applicant did not have a condition that could impair his judgment or reliability in the handling of classified information. On January 10, 2011, the LCDP indicated that Applicant was repentant about his relapse and free of illicit drugs since then. Applicant had made significant progress in his therapy sessions with her, and he was motivated to abstain from illegal drugs. (GE 27.) As of May 22, 2012, Applicant was seeing this therapist once every two weeks. Applicant continued to report to the LCDP that he had been abstinent from marijuana since October 22, 2010. In her opinion, Applicant was mentally stable, and he had a fair to good prognosis for remaining abstinent from marijuana. (AE A.)

On December 31, 2010, in response to DOHA interrogatories, Applicant indicated that he had not consumed alcohol since about 1999 or when he made his statement. He denied any intent to drink alcohol in the future. He answered affirmatively to whether he had used an illegal drug since June 2010, and he disclosed that he used cannabis on October 9, 2010, and October 17, 2010 (GE 10), although he is now not sure whether that is accurate. (Tr. 98.) On April 20, 2011, in response to DOHA inquiry into any illegal drug use since October 2010, Applicant reported that he used cannabis between November 2, 2010 and November 30, 2010, "1 time rolled." (GE 11.)

In late November 2010, Applicant's current psychiatrist reported that Applicant was doing "much better." On April 21, 2011, he opined that Applicant did not have a condition that could impair his judgment, reliability, or ability to properly safeguard classified information provided Applicant was taking his prescribed medications. He gave Applicant a good prognosis. (GE 26.) As of June 2012, Applicant was seeing this psychiatrist once every three months. (Tr. 105.)

Applicant attributes his manic episodes to the ineffectiveness of his psychiatric medications, questioning in particular the long-term safety and effectiveness of Depakote for managing bipolar disorder. He contends that he raised the issue repeatedly with the psychiatrist who treated him from December 2002 until June 2009. (Tr. 68.) Also, Applicant questions the appropriateness of his current Effexor XR medication on the basis that the drug has not been approved for bipolar disorder and has extensive side effects.[5] (Tr. 69.) Applicant testified that the side effects of his medications increased gradually to where he eventually experienced fatigue, somnolence, sedation, and Parkinsonism with the Risperdal and abnormal dreams, agitation, confusion, depression, hallucinations, and thinking abnormalities with the Depakote. (Tr. 71-72.) He indicated that he also had side effects from his Effexor XR and Lamictal, including confusion and depersonalization. (Tr. 74.) Applicant has not been hospitalized for any mental health concerns since 2008, although he continues to experience some side effects from his psychiatric medications, including "trouble with memory" and hearing voices when in very stressful situations. (Tr. 103-04.) Applicant missed a nighttime dose of his medications one evening during the week of May 27, 2012. (Tr. 105.)

Applicant denies any use of marijuana since October or November 2010. (Tr. 81, 95, 99.) Also, he denies knowing before he received the Directive that illegal drug use is prohibited while holding a security clearance. Applicant knew that it was illegal to use marijuana. (Tr. 99.) Since 2010, Applicant has had impulses to use marijuana once every couple of weeks. He deals with these recurring impulses by staying busy. (Tr. 110.) Applicant thought about using marijuana when he received the SOR, but he overcame the impulse by working on his response to the SOR. (Tr. 109-10.) Applicant has discussed the impulses with his counselor, but not with his psychiatrist. The LCDP has told him to stop stressing over his son. (Tr. 111.) Applicant has not seen his son in three months. He believes his son is no longer using marijuana (Tr. 101), although Applicant's decision to stop using marijuana became an issue between them ("Because I stopped and he hadn't and he gave me the hypocritical thing there."). (Tr. 112.) Applicant's spouse credits Applicant with getting his son the professional help that his son needed to stop using marijuana. (Tr. 143-44.) She believes Applicant smoked marijuana in the past with a former co-worker of his. (Tr. 142.) Applicant has smoked marijuana with his next-door neighbor in the past. He has been staying away from him because he knows the neighbor still smokes the drug. (Tr. 112-13.)

Applicant denies that he ever knowingly used any PCP. He attributes the positive drug screen of April 2008 to his Effexor medication. (Tr. 78-80.) As of March 2012, the U.S. Food and Drug Administration (FDA) approved a supplement to the labeling for Effexor

[5]The drug literature substantiates Applicant's concern. Effexor XR is approved for treatment of major depressive disorder. It has not been approved for use in treating bipolar depression. The drug literature indicates that prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder because while not established in controlled trials, it is generally believed that treating an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. (AE J.)

(venlafaxine HCL) tablets and Effexor XE extended-relapse capsules to include the following:

> **Drug-Laboratory Test Interactions**
> False positive urine immunoassay screening tests for phencyclidine (PCP) and amphetamine have been reported in patients taking venlafaxine. This is due to lack of specificity of the screening tests. False positive test results may be expected for several days following discontinuation of venlafaxine therapy. Confirmatory tests, such as gas chromatography/mass spectrometry, will distinguish venlafaxine from PCP and amphetamine. (AEs C, J.)

Applicant's spouse began to notice some improvement in Applicant's mental health a couple of years ago. (Tr. 123.) She is now able to talk Applicant out of a depressed state and persuade him to focus on the present, which she was unable to do previously, especially when Applicant was on Depakote medication. (Tr. 146-47.)

Character reference letters from coworkers familiar with Applicant's work performance from 1995 to 2002 attest to Applicant's dependability, reliability, and high personal integrity over that period. Applicant planned his time well and could be relied on to accomplish his assignments with little or no supervision. He was an excellent machinist, who had a "knack for making solutions to complicated problems clear to others and [had] great patience explaining tasks to those of lesser abilities." Applicant exhibited no rash or extreme behavior at the workplace. (AE N.) A coworker, who has known Applicant for more than 15 years, describes Applicant as a "cooperative person who extends himself to assist others." Applicant completed the task of building a pipe-cutting and beveling machine on time and under budget. (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(c), 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 access to classified information will be resolved in favor of 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 as to potential, rather than actual, risk of compromise of classified information. Section 7 of Executive Order 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 I—Psychological Conditions

The security concern for psychological conditions is set out 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 medical health professional (e.g., clinical psychologist or psychiatrist) employed by, or acceptable to and approved by the U.S. Government, should be consulted when evaluating potentially disqualifying and mitigating information under this guideline. No negative inference concerning the standards in this Guideline may be raised solely on the basis of seeking mental health counseling.

A diagnosis of bipolar disorder is not per se disqualifying, and no negative inferences are raised solely on the basis of counseling or medication management for the condition. However, Guideline I concerns are raised when the mental health condition is not adequately managed and results in behavior that casts doubt on judgment, reliability, or trustworthiness. Applicant required treatment at a psychiatric facility in 1992 when, in a confused state, he confronted the mother of his son at church services. In July 1996, he stopped taking his Depakote medication while on vacation. It led to assaultive, violent behavior and eventual psychosis, necessitating his psychiatric hospitalization. After a

period of mental health stability, he was disoriented at his work place in April 2004 after he had stopped taking his Depakote medication, and he was readmitted to a psychiatric hospital. In March 2007, during a period of work stress, he had a hypomanic episode at a gas station and was involuntarily committed to a psychiatric hospital for five days. In December 2007, after not taking his psychiatric medications, Applicant became violent with his spouse, and he appeared psychotic and disorganized ("talking nonsense") at the hospital. In April 2008, he had another episode of psychosis after his supply of Lamictal ran out. AG ¶ 28(a), "behavior that casts doubt on an individual's judgment, reliability, or trustworthiness that is not covered under any other guideline, including but not limited to emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behavior," is established.

Applicant attributes his episodes of dysfunctional behavior to the gradual ineffectiveness of certain psychiatric medications and extensive side effects of the various drugs. He questions in particular the long-term safety of Depakote for managing his bipolar disorder, and the fact that Effexor XR, which he has taken since March 2007, has not been approved for treatment of bipolar disorder. The drug literature supports his position to the extent that Effexor XR has not been approved for treatment of bipolar depression, although the clinical concern appears to be treating bipolar disorder with Effexor XR alone. Applicant suffers from a chronic mental health condition that may require changes in medication or dosages for effective management. He has been prescribed an antipsychotic (initially Risperdal and more recently Invega) to manage the mania associated with bipolar disorder, in addition to antidepressants. I am not in a position to question the appropriateness of the treatment protocol prescribed by medically-qualified providers. The exacerbations of his mental illness followed his failure to take the prescribed psychiatric medications Depakote in 1996 and 2002, and Lamictal in 2008. While Applicant may have missed doses of his psychiatric medications at times due to confusion or lack of routine, he allowed his supply of Lamictal to run out in 2008. Also, he continued to smoke marijuana until the fall of 2010, and to drink alcohol until at least 2007, after being advised that the substances could reduce the effectiveness of his psychiatric medications. AG ¶ 28(c), "the individual has failed to follow treatment advice related to a diagnosed emotional, mental, or personality condition, e.g., failure to take prescribed medication," is established.

AG ¶ 28(b), "an opinion by a duly qualified mental health professional that the individual has a condition not covered under any other guideline that may impair judgment, reliability, or trustworthiness," is not met, despite his history of episodic, unstable behavior. Applicant's treating psychiatrist opined in April 2011 that Applicant did not have a condition that could impair his judgment, reliability, or ability to properly safeguard classified national security information "while taking prescribed medication." In May 2012, the LCDP, who has counseled him since June 2010, assessed his mental health condition as stable. The evidence substantiates that Applicant's diagnosed bipolar disorder does not sufficiently impair his judgment, provided he is complying with his treatment.

Applicant satisfies the first component of mitigating condition AG ¶ 29(a), "the identified condition is readily controllable with treatment." Yet, his erratic compliance with his treatment has had negative consequences for his judgment and reliability, and it

precludes full application of AG ¶ 29(a), which also requires that "the individual has demonstrated ongoing and consistent compliance with the treatment plan."

Applicant's treating psychiatrist gave him a good prognosis in April 2011, and his therapist considers his present mental health to be stable. The favorable prognosis from the psychiatrist implicates AG ¶ 29(b), "the individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a duly qualified mental health professional," but it was contingent on Applicant taking his medications as prescribed. Applicant and his spouse have noticed improvement in his mental state under his current medication regimen. Yet, previous medications like Risperdal and Depakote were initially successful in managing his condition only to become less effective over time. Furthermore, Applicant admits that he missed a dose of his psychiatric medications within a week of his security clearance hearing. His relapse history is difficult to overcome without a recent assessment by a qualified mental health professional that his condition has a low probability of recurrence or exacerbation despite missing doses of his medication, and recurrent impulses to use marijuana. Applicant's therapist considers Applicant's present mental health to be stable, but her expertise is in substance abuse issues. The psychological conditions security concerns are not fully mitigated.

Guideline G—Alcohol Consumption

The security concern for alcohol consumption is set out 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 drank alcohol against therapeutic advice, knowing that it could impair the effectiveness of the prescription medications needed to adequately manage his bipolar disorder. He was diagnosed with alcohol abuse-episodic when hospitalized following the incident at the motel in 1996. Applicant had consumed beer while on vacation, and he attributes his agitated and incoherent state to alcohol interfering with his medications. However, his confused mental state was more likely caused by his failure to take his prescribed psychiatric medication for a few days. Between November 1999 and September 2000, Applicant drank four or five beers at bars after work before driving home, resulting in diminished effectiveness of at least one of his psychiatric medications. At DOHA's request, Applicant underwent a substance abuse evaluation in February 2002 by a PhD and LCSW-credentialed senior clinician affiliated with a substance abuse treatment facility. This substance abuse professional found no indication of a current alcohol dependency or alcohol abuse problem. Applicant acknowledged during his psychiatric hospitalization in March 2007 that he was using alcohol occasionally, despite knowing that it could interfere with his mental health, and his spouse suspected in December 2007 that alcohol played a role in his violent behavior, although Applicant denied he had been drinking.

AG ¶ 22(c), "habitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed as an alcohol abuser or alcohol dependence," has limited applicability to Applicant's drinking between 1999 and

2000, when he was consuming up to five 12-ounce beers at bars after work before going home. To the extent that AG ¶ 22(d), "diagnosis by a duly qualified medical professional (e.g., physician, clinical psychologist, or psychiatrist) of alcohol abuse or alcohol dependence," and AG ¶ 22(e), "evaluation of alcohol abuse or alcohol dependence by a licensed clinical social worker who is a staff member of a recognized alcohol treatment program," are established because Applicant was diagnosed with alcohol abuse, mitigating conditions apply.

Applicant told DOHA in March 2002 that he had chosen to cease his alcohol consumption because he realized that the interaction between alcohol and his prescribed psychiatric medications could result in unacceptable behavior. He drank occasionally until at least March 2007, in contravention of medical advice, but not to intoxication. However, Applicant has abstained from alcohol for long enough to apply AG ¶ 23(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." Applicant denies he had an alcohol problem, although he recognizes that alcohol could impair the effectiveness of his psychiatric medications, and he had stopped drinking as a result. So, there is a basis to apply AG ¶ 23(b), "the individual acknowledges his or her alcoholism or issues of alcohol abuse, provides evidence of actions taken to overcome this problem, and has established a pattern of abstinence (if alcohol dependent) or responsible use (if an alcohol abuser)." The alcohol consumption issues are mitigated because he is not likely to abuse alcohol in the future.

Guideline H—Drug Involvement

The security concern for drug involvement is set out in AG ¶ 24:

> Use of an illegal drug or misuse of a prescription drug can raise questions about an individual's reliability and trustworthiness, both because it may impair judgment and because it raises questions about a person's ability or willingness to comply with laws, rules, and regulations.

Under AG ¶ 24(a), drugs are defined as "mood and behavior altering substances," and include:

> (1) Drugs, materials, and other chemical compounds identified and listed in the Controlled Substances Act of 1970, as amended (e.g., marijuana or cannabis, depressants, narcotics, stimulants, and hallucinogens),[6] and
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> (2) inhalants and other similar substances.

Under AG ¶ 24(b), drug abuse is defined as "the illegal use of a drug or use of a legal drug in a manner that deviates from approved medical direction." Potentially

[6]Schedules I, II, III, IV, and V of the Controlled Substances Act, are set forth in 21 U.S.C. § 812(c).

disqualifying conditions AG ¶ 25(a), "any drug abuse," ¶ 25(c), "illegal drug possession, including cultivation, processing, manufacture, purchase, sale or distribution; or possession of drug paraphernalia," and AG ¶ 25(g), "any illegal drug use after being granted a security clearance," apply. Applicant abused marijuana with varying frequency from about 1983 to November 2010. He also purchased marijuana on occasion. Applicant abstained from marijuana for six months from 2001 into 2002, but he resumed smoking after he was granted his secret clearance. Applicant had marijuana and a wooden pipe for smoking in his possession in March 2007. Applicant was arrested on drug charges and then taken to the emergency room due to his bizarre behavior. He was abusing the drug at the time of his psychiatric break in April 2008, and he relapsed in 2010.

Applicant tested positive for marijuana in March 2007. During his psychiatric admission in December 2007, a urine sample was positive for marijuana and PCP. A toxicology screen of April 14, 2008, submitted while he was under evaluation for emergency commitment to a mental health bed, was positive for marijuana and PCP. AG ¶ 25(b), "testing positive for illegal drug use," was not alleged as a basis for disqualification, although the drug screens are still relevant in that they confirm his use of marijuana. The evidence falls short of establishing that he knowingly abused PCP. The FDA recently approved supplemental labeling for Effexor XR to warn of false-positive urine immunoassay screening tests for PCP and amphetamine for patients taking Effexor. Applicant had been on Effexor XR since March 2007, so the possibility of a false positive cannot be discounted. A more recent drug screen in July 2010 detected marijuana but no other illegal drug. Applicant's abuse of other controlled dangerous substances was limited to one-time mescaline use in July 1989.

AG ¶ 25(d), "diagnosis by a duly qualified medical professional (e.g., physician, clinical psychologist, or psychiatrist) of drug abuse or drug dependence," is satisfied as well. Medical records from his psychiatric admission in December 2007 indicate that he was diagnosed with marijuana abuse, in addition to bipolar disorder and alcohol abuse. On his admission to another psychiatric facility in April 2008, he was diagnosed with bipolar disorder, cannabis dependence, and hallucinogen abuse, although the psychiatrist who evaluated him at the facility listed only the bipolar disorder as his primary diagnosis.

Concerning the potentially mitigating conditions, AG ¶ 26(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," is difficult to apply. Applicant abused marijuana for about 27 years, despite being told that it could compromise his mental stability. The frequency of his marijuana abuse increased from twice weekly as of March 2007 to daily as of April 2008, after he was sentenced for marijuana possession, and his spouse expressed concerns about his drug abuse and the need to set a good example for his son. While in counseling with the LCDP, and after urinalysis testing was instituted to "force him to answer to [himself]," Applicant abused marijuana in October 2010 and November 2010.[7]

[7]Applicant told his LCDP that he relapsed from October 14-21, 2010, and that he has been free of marijuana since October 22, 2010. (AE A.) On December 31, 2010, he told DOHA that he used marijuana since June 2010: on October 9, 2010, and again on October 17, 2010. (GE 10.) On April 20, 2011, Applicant indicated

Concerning AG ¶ 26(b), "a demonstrated intent not to abuse any drugs in the future," can be shown by "(1) disassociation from drug-using associates and contacts; (2) changing or avoiding the environment where drugs were used; (3) an appropriate period of abstinence; or (4) a signed statement of intent with automatic revocation of clearance for any violation." Applicant told an OPM investigator in October 2008 that he had stopped using marijuana in December 2007 and did not intend to continue illegal drug use. Yet, in 2009, he indicated that he smoked marijuana "5 times a week or less" from April 2007 to April 2010. He abused marijuana well after he claimed to have stopped. Given his many years of marijuana abuse, and his previous lack of candor about his illegal drug involvement, it is difficult to apply AG ¶ 26(b) without substantial evidence corroborating his intent not to abuse marijuana in the future. Applicant's counseling with the LCDP since June 2010 weighs in his favor in assessing his commitment to abstain. That said, the counselor reports that Applicant has abstained since October 22, 2010. Applicant appears not to have shared with his therapist that he used marijuana at least once after October 2010. Applicant's spouse is persuaded that he no longer uses marijuana, but she appears not to know the full extent of his marijuana involvement. She believes that Applicant used marijuana with only one friend, a former co-worker, while Applicant admits that he smoked the drug with his son and with his next-door neighbor. Furthermore, Applicant's spouse testified that her stepson has "come clean" (i.e., stopped his drug use) with Applicant's help, while Applicant testified that his decision to stop smoking marijuana caused him to become estranged from his son, who accused him of being hypocritical. Even if I accept that Applicant is no longer associating with his neighbor, and that he intends no future involvement, a lengthier period of abstention is needed to fully satisfy AG ¶ 26(b) in his case.

AG ¶ 26(d), "satisfactory completion of a prescribed drug treatment program, including but not limited to rehabilitation and aftercare requirements, without recurrence of abuse, and a favorable prognosis by a duly qualified medical professional," is minimally established. Applicant is still in counseling every two weeks with the LCDP, who assessed his prognosis for remaining abstinent as fair to good. It is unclear whether she knows about his recurrent impulses to use marijuana. The drug involvement concerns are not fully mitigated.

Guideline E, Personal Conduct

The security concerns about personal conduct are set out in AG ¶ 15:

> Conduct involving questionable judgment, lack of candor, dishonesty, or unwillingness to comply with rules and regulations can raise questions about an individual's reliability, trustworthiness and ability to protect classified information. Of special interest is any failure to provide truthful and candid answers during the security clearance process or any other failure to cooperate with the security clearance process.

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that he used marijuana one time since October 2010: one time from November 1-30, 2010. (GE 11.)

The Government established its Guideline E case in that Applicant exercised poor judgment by abusing marijuana and alcohol knowing that it could impair the effectiveness of his psychiatric medications. Applicant's repeated disregard of therapeutic advice not to drink alcohol or use marijuana primarily implicates AG ¶ 16(c):

> Credible adverse information in several adjudicative issue areas that is not sufficient for an adverse determination under any single guideline, but which, when considered as a whole, supports a whole-person assessment of questionable judgment, untrustworthiness, unreliability, lack of candor, unwillingness to comply with rules and regulations, or other characteristics indicating that the person may not properly safeguard protected information.

As for him abusing marijuana while holding a secret clearance, Applicant claims he did not understand that marijuana use was contrary to his security responsibilities. At the same time, Applicant admits that he knew it was illegal to use marijuana. Applicant cannot reasonably claim that he failed to realize that marijuana use was inconsistent with security requirements. He falsely denied any illegal drug use on his February 2000 and February 2006 security clearance applications. On his September 2008 e-QIP, he reported only his marijuana abuse from February 2007 to December 2007. This misrepresentation of his illegal drug involvement was repeated during his October 2008 interview. Applicant's dishonesty is conduct contemplated within AG ¶ 16(a) ("Deliberate omission, concealment or falsification of relevant facts from any personnel security questionnaire, personal history statement, or similar form used to conduct investigations, determine employment qualifications, award benefits or status, determine security clearance eligibility or trustworthiness, or award fiduciary responsibilities") and AG ¶ 16(b) ("deliberately providing false or misleading information concerning relevant facts to an employer, investigator, security official, competent medical authority, or other official government representative"). The Government did not allege lack of candor as an issue of security concern under Guideline E,[8] although it is relevant to Applicant's security suitability. Applicant's use of marijuana while holding a security clearance implicates AG ¶ 16(e):

> (e) personal conduct, or concealment of information about one's conduct, that creates a vulnerability to exploitation, manipulation, or duress, such as

[8]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:

> (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 the whole-person analysis under Directive Section 6.3.

(citing ISCR Case No. 02-07218 at 3 (App. Bd. Mar. 15, 2004); ISCR Case No. 00-0633 at 3 (App. Bd. Oct. 24, 2003)). I have considered the non-SOR misconduct for the five above purposes, and not for any other purpose.

(1) engaging in activities which, if known, may affect the person's personal, professional, or community standing.

Applicant continued to abuse marijuana from March 2002 until November 2010 in disregard of its illegality and of his security responsibilities, and despite knowing it was contraindicated for his psychiatric medications. It is too serious and repeated to be mitigated under AG ¶ 17(c), "the offense is so minor, or so much time has passed, or the behavior is so infrequent, or it happened under such unique circumstances that it is unlikely to recur and does not cast doubt on the individual's reliability, trustworthiness, or good judgment," even if his alcohol abuse against medical advice is now mitigated by the passage of time. Applicant's ongoing counseling with the LCDP since late June 2010 warrants some consideration of AG ¶ 17(d):

> (d) the individual has acknowledged the behavior and obtained counseling to change the behavior or taken other positive steps to alleviate the stressors, circumstances, or factors that caused untrustworthy, unreliable, or other inappropriate behavior, and such behavior is unlikely to recur.

Applicant sees his therapist every other week and his psychiatrist once every three months. His therapist has given him a fair to good prognosis for remaining abstinent from marijuana. While Applicant is making constructive use of his time through home improvements projects, he continues to experience anxiety over family matters and impulses to abuse marijuana. Especially in light of his history, I cannot safely conclude that his marijuana use is safely behind him, so AG ¶ 17(d) does not fully apply.

AG ¶ 17(e), "the individual has taken positive steps to reduce or eliminate vulnerability to exploitation, manipulation, or duress," applies in part, in that the Government is now aware that Applicant used marijuana at risk to his mental health and to national security interests. However, the evidence also shows that Applicant has not been fully frank with his spouse about his marijuana involvement. Moreover, it is unclear whether any of his character references is aware of Applicant's illegal drug abuse. AG ¶ 17(f), "the information was unsubstantiated or from a source of questionable reliability," applies only in that the Government failed to establish that Applicant knowingly abused PCP in contravention of medical advice at risk to the effectiveness of his psychiatric medications or DOD security clearance requirements.

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(a).[9] In making the overall commonsense determination required under AG ¶ 2(c), I have

[9]The factors under AG ¶ 2(a) 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

to consider that certain medications may be less effective over time in managing his bipolar disorder. Admissions of drug and alcohol abuse from Applicant when he was in a manic or psychotic state are potentially suspect in light of his compromised mental health. That being said, Applicant knowingly used marijuana and alcohol after being told that such mood-altering substances could impair the effectiveness of his psychiatric medications. He continued to smoke marijuana despite his spouse's expressed approval. While he may not have been aware of a specific DOD policy against illicit substance use, he certainly suspected that it would not be condoned because he concealed his abuse when he applied for his security clearance. Applicant's ongoing counseling with the LCDP is a very important step in reform, but given his history of erratic compliance with his mental health treatment and his many years of marijuana abuse, I cannot conclude that it is clearly consistent with the national interest to continue his security clearance at this time.

Formal Findings

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

Paragraph 1, Guideline I:	AGAINST APPLICANT
Subparagraph 1.a:	Against Applicant
Paragraph 2, Guideline G:	FOR APPLICANT
Subparagraph 2.a:	For Applicant
Paragraph 3, Guideline H:	AGAINST APPLICANT
Subparagraph 3.a:	Against Applicant
Subparagraph 3.b:	Against Applicant
Subparagraph 3.c:	Against Applicant
Paragraph 4, Guideline E:	AGAINST APPLICANT
Subparagraph 4.a:	Against Applicant

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 presented by the record in this case, it is not clearly consistent with the national interest to grant Applicant eligibility for a security clearance. Eligibility for access to classified information is denied.

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Elizabeth M. Matchinski
Administrative Judge