United States Department of Energy
Office of Hearings and Appeals

In the Matter of: Personnel Security Hearing	)		
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Filing Date: July 22, 2024	)	Case No.:	PSH-24-0156
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Issued: January 14, 2025

Administrative Judge Decision

Janet R. H. Fishman, Administrative Judge:

This Decision concerns the eligibility of XXXXXXXXXXXXX (the Individual) to hold an access authorization under the United States Department of Energy's (DOE) regulations, set forth at 10 C.F.R. Part 710, "Procedures for Determining Eligibility for Access to Classified Matter and Special Nuclear Material or Eligibility to Hold a Sensitive Position."[1] As discussed below, after carefully considering the record before me in light of the relevant regulations and the *National Security Adjudicative Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position* (June 8, 2017) (Adjudicative Guidelines), I conclude that the Individual's access authorization should not be restored.

I. BACKGROUND

The Individual is employed by a DOE contractor in a position that requires him to hold an access authorization. Exhibit (Ex.) 1 at 6.[2] The Individual underwent a psychological evaluation in April 2024 by a DOE-consultant psychologist (DOE Psychologist). Ex. 8 at 35–36. In his report (Report), the DOE Psychologist concluded that the Individual habitually or binge consumed alcohol to the point of impaired judgment. *Id.* at 41. The DOE Psychologist also concluded that the Individual met sufficient *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition – Text Revision* (*DSM-5-TR*)[3] criteria for diagnoses of (1) Substance Use Disorder, without

[1] The regulations define access authorization as "an administrative determination that an individual is eligible for access to classified matter or is eligible for access to, or control over, special nuclear material." 10 C.F.R. § 710.5(a). This Decision will refer to such authorization as "access authorization" or "security clearance."

[2] The Local Security Office's (LSO) exhibits were combined and submitted in a single, 273-page PDF workbook. References to the LSO's exhibits are to the exhibit number and the Bates number located in the top right corner of each exhibit page.

[3] The Summary of Security Concerns (SSC), when citing to the DOE Psychologist's Report, refers to the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* rather than the *DSM-5-TR*. *Compare* Ex. 1 at 5 (SSC) *with* Ex. 8 at 43 (DOE Psychologist's Report). This Decision will refer to the DOE

adequate evidence of rehabilitation or reformation; (2) Major Depression; and (3) Generalized Anxiety Disorder. *Id.* at 41–42. The Local Security Office (LSO) subsequently informed the Individual in a Notification Letter that it possessed reliable information that created substantial doubt regarding his eligibility for access authorization. Ex. 1 at 5. In the Summary of Security Concerns (SSC) attached to the letter, the LSO explained that the derogatory information raised security concerns under Guidelines G and I of the Adjudicative Guidelines. *Id.*

The Individual exercised his right to request an administrative review hearing pursuant to 10 C.F.R. Part 710. Ex. 2 at 10. The Director of the Office of Hearings and Appeals (OHA) appointed me as the Administrative Judge in this matter, and I conducted an administrative hearing. The LSO submitted ten exhibits (Ex. 1–10). The Individual submitted four exhibits (Ex. A–D).[4] The Individual testified on his own behalf and offered the testimony of three additional witnesses. Hearing Transcript, OHA Case No. PSH-24-0156 (Tr.) at 10–55, 56–64, 66–72, 74–89. The LSO called the DOE Psychologist to testify. *Id.* at 91–119.

II. THE SECURITY CONCERNS

The LSO cited to Guideline G (Alcohol Consumption) as a basis for its substantial doubt regarding the Individual's eligibility for access authorization. Ex. 1 at 5. "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." Adjudicative Guidelines at ¶ 21. In citing Guideline G, the LSO relied upon the DOE Psychologist's Report from April 2024 (1) finding that the Individual met sufficient diagnostic criteria under the *DSM-5-TR* for a diagnosis of substance use disorder,[5] without adequate evidence of rehabilitation or reformation, and (2) concluding that the Individual habitually or binge consumes alcohol to the point of impaired judgment. Ex. 1 at 5. The LSO's citation to the DOE Psychologist's opinion justifies its invocation of Guideline G. Adjudicative Guidelines at ¶ 22(c)–(d) (listing as security concerns "habitual or binge consumption of alcohol to the point of impaired judgment" and "diagnosis by a duly qualified medical or mental health professional . . . of alcohol use disorder").

The LSO cited Guideline I (Psychological Conditions) as the other basis for its substantial doubt regarding the Individual's eligibility for access authorization. Ex. 1 at 5. "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." Adjudicative Guidelines at ¶ 27. The SSC cited the DOE Psychologist's finding that the Individual met sufficient diagnostic criteria under the *DSM-5-TR* for diagnoses of Major Depression and Generalized Anxiety Disorder and that either condition could impair judgment, stability, reliability, or trustworthiness if left untreated. Ex. 1 at 5. The LSO's citation of the DOE Psychologist's opinion justifies the LSO's invocation of Guideline I. Adjudicative Guidelines at ¶ 28(b) (identifying that

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Psychologist's diagnosis as made pursuant to the *DSM-5-TR* criteria, which is the version of the *Diagnostic and Statistical Manual* referenced in the Report.

[4] Exhibits A through C were submitted as a single PDF. Citations to Exhibits A through C are to the PDF page number in the order in which the pages appear.

[5] The DOE Psychologist used the term "substance use disorder" but used the *DSM-5-TR* diagnostic criteria for "alcohol use disorder." *See* Ex. 8 at 43–44.

a security concern may arise from "an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness").

III. REGULATORY STANDARDS

A DOE administrative review proceeding under Part 710 requires me, as the Administrative Judge, to issue a Decision that reflects my comprehensive, common-sense judgment, made after consideration of all the relevant evidence, favorable and unfavorable, as to whether the granting or continuation of a person's access authorization will not endanger the common defense and security and is clearly consistent with the national interest. 10 C.F.R. § 710.7(a). The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Dep't of Navy v. Egan*, 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for granting security clearances indicates "that security determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990) (strong presumption against the issuance of a security clearance).

The Individual must come forward at the hearing with evidence to convince the DOE that granting or restoring access authorization "will not endanger the common defense and security and will be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). The Individual is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The Part 710 regulations are drafted to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. *Id.* § 710.26(h). Hence, an individual is afforded the utmost latitude in the presentation of evidence to mitigate the security concerns at issue.

IV. FINDINGS OF FACT AND HEARING TESTIMONY

a. Individual's Background, Alcohol Use, Treatment, and Related Testimony

The Individual reported having been anxious his whole life. Ex. 8 at 40; Tr. at 13. He began drinking shortly after he turned 21 in around 2016. Ex. 8 at 38, 40; Tr. at 14. For the first few years he drank, the Individual drank "maybe a few times per month, socially . . . with friends." Tr. at 32. In 2021, his drinking increased due to stress related to the COVID-19 pandemic. *Id.* at 13, 32 (Individual testifying "when COVID-19 hit, that's when [his drinking] got more intense"); Ex. 8 at 40 (reporting to the DOE Psychologist that in 2021 he started drinking about two to three alcoholic beverages per night). He testified that his alcohol consumption underwent a "gradual ramp" up and that "in 2023[] and [ ] into 2024" he was drinking about half of a 750-mL bottle of 80-proof whiskey per day, most days per week. Tr. at 32–33; *see also* Ex. 8 at 40. The Individual indicated that he typically drank this amount alone in his apartment. Tr. at 53.

In November 2023, the Individual's friends and family recommended that the Individual seek a therapist. *Id*. at 30–31. The Individual explained that, because he had never been through this process before, and also because of the holiday season and a lack of responsiveness from professionals' offices, he experienced delays in identifying a care provider. *Id.* On January 22, 2024, the Individual consumed a full 750-mL bottle of whiskey over a 12-hour period. Ex. 8 at 39; Tr. at 18. The Individual reported feeling stressed from work, having difficulty sleeping, and drinking this amount as "self-harm." Ex. 7 at 25; *see also* Ex. 8 at 39 (reporting to the DOE Psychologist that "he wanted to punish or hurt himself"); Tr. at 18 (Individual testifying that

leading up to the incident he "was feeling pretty down about not being able to see some family due to people having COVID . . . , a lot of stressors coming back to work, and social anxieties . . ."). The Individual eventually regurgitated the alcohol and fell asleep. Ex. 8 at 39. When he awoke the next day, he called his significant other (Significant Other), and she arrived at his residence. *Id.*; Tr. at 20. She stayed with the Individual so he would not be alone. Ex. 8 at 39.

The Individual testified that up until then, he "didn't ever feel out of control" with respect to his alcohol use. Tr. at 32–33. However, the January 22, 2024, incident made him realize that his alcohol use had become a problem. *Id.* at 33. He further testified that he "was feeling like [he] wanted to stop" and "fe[eling] discouraged because [he] thought [he had] gone past the point where [he] can do it" by himself. *Id.* at 33–34. Accordingly, he "began looking for outside help." *Id.*

Immediately after the January 22, 2024, incident, the Individual and his Significant Other researched healthcare providers with whom the Individual could speak. Ex. 8 at 39; Tr. at 20. The Individual testified to meeting with two different therapists through his employer's Employee Assistance Program (EAP). Tr. at 20–21; *see also* Ex. 7 at 25 (Individual's response to a Letter of Interrogatory (LOI) indicating he spoke with an EAP therapist in late January 2024). The Individual also met with an in-patient substance abuse treatment program. Tr. at 21; Ex. 7 at 25 (response to LOI indicating he met with the in-patient program in late January 2024). The Individual testified that he took an assessment with the in-patient program, "ultimately deciding that [the program] wasn't what [he] needed." Tr. at 21 (stating that "I went there and took one of their assessments, ultimately deciding that that wasn't what I needed."); Ex. 7 at 25 (response to LOI indicating that "[i]t was determined in-patient care was not required . . .").

In March 2024, the Individual voluntarily began seeing a psychiatrist. Tr. at 18, 22–23; *see also* Ex. 8 at 39. As of the hearing, the Individual remained under the psychiatrist's care and testified that the psychiatrist had directed the following treatment elements: (1) appointments occurring every six weeks; (2) taking medications as prescribed; and (3) attending SMART Recovery[6] sessions. Tr. at 22–23, 25–27, 41–42. The Individual indicated that, outside of the recurring appointments, his psychiatrist remained available for communication via a patient portal. *Id.* at 26–27. He further testified that he intends to keep seeing the psychiatrist indefinitely. *Id.* at 47.

At the beginning of his treatment, the Individual, at the direction of his psychiatrist, started taking medication to assist with addictions to alcohol and nicotine, as well as his trouble sleeping. Tr. at

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[6] SMART stands for Self-Management and Recovery Training. According to its website,

> SMART [program] is an evidenced-based recovery method grounded in Rational Emotive Behavioral Therapy (REBT) and Cognitive Behavioral Therapy (CBT), that supports people with substance dependencies or problem behaviors to:
>
> 1. Build and maintain motivation
> 2. Cope with urges and cravings
> 3. Manage thoughts, feelings and behaviors
> 4. Lead a balanced life

What is SMART Recovery?, SMART Recovery, https://smartrecovery.org/what-is-smart-recovery (last visited Jan. 13, 2025).

22. Thereafter, in May 2024, he received two medications for his anxiety. *Id.* At the time of the hearing, the Individual testified he still took "all four of those medications, as directed . . . ." *Id.* He testified the anxiety medication has "certainly assisted" him and that his "base level has definitely improved with the medication[ ]." *Id.* at 27–28. Regarding his addiction medication, the Individual described its effect as "eliminat[ing] the good feelings of drinking[ ] [s]o there's less desire . . . to engage in that activity . . . ." *Id.* at 35.

On July 10, 2024, the Individual checked into an emergency room and was hospitalized with symptoms of delirium and nausea and unable to keep liquids or food down. *Id.* at 24. The Individual's Significant Other testified that the Individual had tried to quit alcohol use "cold turkey" and that he was going through "more severe symptoms of . . . alcohol withdrawal . . ." including "delusions" and "shaking." *Id.* at 80–81. The Individual received an IV drip for potassium and magnesium and remained in the hospital for two days. *Id.* at 24.

In the late spring or early summer of 2024, the Individual and his psychiatrist discussed therapy options.[7] *Id.* at 25. He testified that he started attending SMART Recovery group sessions "in keeping with [the psychiatrist's] care plan for [him]." *Id.* at 25–26; *see also* Ex. A at 2–12 (SMART Recovery attendance records showing that he attended sessions on July 15, August 19, September 2, September 9, and September 16, 2024); Ex. D at 3 (SMART Recovery attendance records showing that he attended sessions on September 23, October 3, November 7, and November 11, 2024).[8] The Individual testified "group [sessions] ha[d] really helped with[ ] providing tools[,]" including "strategies . . . and ways to recognize . . . when something might be a problem" or "how to see it before it becomes a problem." Tr. at 28. Other strategies he learned include (1) going into situations where alcohol is present with a prior plan or strategy, (2) developing a hierarchy of values to prioritize over alcohol, and (3) identifying triggers.[9] *Id.* at 39–41. He further testified that the other members provide advice and have made themselves available to meet outside of the group setting to discuss and provide advice. *Id.* at 39. As a result of the SMART Recovery, he testified to "ma[king] it through several holidays where alcohol was present and abstained." *Id.* at 28.

The Individual submitted into the record a "Pledge to Abstain [from] Alcohol Misuse":

> I, [Individual's name], wish to proudly and confidently state that I pledge to continue to remain free from all alcohol abuse. Furthermore, I fully acknowledge, understand, and embrace that any future involvement with alcohol or alcohol use misconduct of the same will be grounds for revocation of my security clearance and any national security eligibility.

[7] While the Individual and his psychiatrist discussed individual therapy for his addiction, at the time of the hearing, he had not yet attended. *Id.* at 41–42. He had also not participated in a substance abuse treatment program with a licensed provider knowledgeable in the area of substance abuse but testified to planning to do so. *Id.* at 44–45. The Individual testified that he had promised his Significant Other that he would contact her therapist's office, who employed addiction specialists, to start attending sessions after the hearing. *Id.* at 41–42.

[8] The Individual estimates that he attended four or five other SMART Recovery sessions but had not obtained attendance records for those sessions. Tr. at 38.

[9] The Individual testified that his triggers include his isolation and social anxiety. Tr. at 41. He testified that his medication and support of friends and family have helped in coping with these. *Id.*

Ex. B at 14. At the hearing, the Individual explained that the pledge meant that he would "no longer use alcohol as a tool to help with [his] anxiety or . . . stress"; no longer "drink alone"; and "enjoy [alcohol] responsibly . . . [,] meaning in limited quantities, in safe environments." Tr. at 35–36. When asked why the Individual continued to drink alcohol despite his addiction medication eliminating positive feelings associated with consuming alcohol, the Individual testified that he would "have to think about that" and was "not quite sure . . . ." *Id.* at 36. However, the Individual shared, during the hearing, that his goal was "to get to abstinence" and that he had "not reached the finish line of where [he] want[s] to be yet." *Id.* at 37.

The Individual testified that his psychiatrist had "told [him] directly to not quit [alcohol] cold turkey" and that they "were going to work to whittle this down." *Id.* at 44; *see also id.* at 53 (Individual testifying that his psychiatrist never told him to stop drinking and that the psychiatrist never indicated a date by which the Individual was to become sober). The Individual also quoted his psychiatrist regarding his treatment being a "marathon, not a sprint." *Id.* at 36. The Individual indicated that he and his psychiatrist were "adjusting" the time frame for arriving to abstinence "as [they] go." *Id.* at 37.

Since his treatment with his psychiatrist, the Individual reported drinking "[a] lot less individually . . . usually only with friends" and "try[ing] not to keep alcohol in [his] residence . . . ." *Id.* at 34.[10] He estimated that he reduced his alcohol intake by two-thirds or more and that the frequency with which he drinks falls mostly on weekends and includes maybe one or two weekdays. *Id.* The Individual had not submitted any laboratory tests corroborating the reduction in his alcohol intake. *See id.* at 44. The Individual admitted to drinking alcohol "probably eight days" before the hearing, consuming approximately three drinks of whiskey. *Id.* at 34.

The Individual testified that the medication, the support of his friends and family, and the SMART Recovery sessions and tools have assisted him in preventing a situation like the January 22, 2024, incident from occurring again. *Id.* at 49–50. As an example, he indicated that his Significant Other attended a SMART Recovery program for friends and family that provides them with tools in assisting an individual experiencing addiction. *Id.* at 29. The Individual also testified that several friends are aware of his struggles and have been encouraging. *Id.*

The Significant Other testified to meeting the Individual in 2019 and entering a relationship with him in 2021. *Id.* at 75–76. The Significant Other observed that the Individual "drank a lot more than [she] did, certainly" but had not "realize[d] it was an issue until[ ] that incident in January [2024]." *Id.* at 77. She estimated that, prior to the January 2024 incident, he drank about every night. *Id.* at 84. She became worried for the Individual immediately after he contacted her during the January 22, 2024, incident. *Id.* at 77. (testifying that "[t]he way he had phrased it at the time . . . he was trying to take his life"). As stated above, she assisted the Individual with identifying treatment resources. *Id.* at 78–79. She also testified that she had known about the Individual's anxiety prior to the incident and observed that, since starting treatment, he had made progress in coping with his anxiety. *Id.* at 80. She also noted that the Individual's alcohol consumption had decreased. *Id.* at 84–85 (describing that the Individual since the January 22, 2024, incident "tried

[10] While the Individual "tr[ies] not to keep alcohol in [his] residence," the Individual's Significant Other estimated that there had been a "couple of instances . . . in the last two[-]to[-]three weeks" that the Individual had been drinking alone in his apartment based on her observation of a "bottle or can in his apartment." Tr. at 34, 86–87.

a couple times to go completely cold turkey" for a week or two and then would "relapse and kind of drink a little bit"). The Significant Other testified that she last saw the Individual intoxicated in early November, less than a month before the hearing. *Id.* at 89. The Significant Other believes the Individual can be trusted with access authorization and that his alcohol use has not impacted his ability to hold a clearance. *Id.* at 82.

At the hearing, two friends (Friend 1 and Friend 2) testified on his behalf. Tr. at 56–64, 66–72. Both Friend 1 and Friend 2 have known the Individual for years, having met him through his Significant Other. Tr. at 57, 67. They both indicated they knew of the concerns raised in connection with this hearing, in particular the January 22, 2024, incident and the Individual's treatment for alcohol use. *Id.* at 59, 67. Both had no concerns about the Individual's alcohol use prior to the Individual sharing with them the details of this proceeding. *Id.* at 63, 68, 70. Friend 1 testified to observing the Individual drink socially every one-to-two months and to witnessing him drink one or two drinks on such occasions. *Id.* at 62–63. Friend 2 testified that there was only one time where he felt the Individual "maybe [ ] had consumed a little bit too much" based on the "slurring of his words . . . ." *Id.* at 71. Friend 2 clarified that the Individual was not "a danger to himself or anyone else." *Id.* Friend 1 and Friend 2 indicated the Individual was an honest and trustworthy person. *Id.* at 60–61, 68–69.

b. DOE Psychologist's Report and Testimony

On the day after the January 22, 2024, incident, the Individual initially informed his supervisor that he was taking vacation time because he was helping with a friend suffering a mental health crisis. Ex. 6 at 23; Ex. 7 at 29; Ex. 8 at 39; *see also* Tr. at 19 (Individual testifying to taking vacation time he had accrued). The Individually eventually told his supervisor the reason for taking annual leave, and his supervisor thereafter informed the LSO on February 5, 2024. Ex. 6 at 23. On April 24, 2024, at the request of the LSO, the Individual underwent a psychological evaluation conducted by the DOE Psychologist. Ex. 8 at 35–57. The evaluation consisted of a clinical interview; a Minnesota Multiphasic Personality Inventory 3rd Edition (MMPI-3); and a Phosphatidylethanol (PEth)[11] test, the results of which were interpreted by a consultant psychiatrist. *Id.* at 39–47. During the clinical interview, the Individual recounted his history of anxiety—specifically in social situations; his history of alcohol use; the events surrounding the January 22, 2024, incident; and his subsequent treatment history with his psychiatrist. *Id.* at 39–40.

The results of the MMPI-3 were reported as follows:

> [The Individual] completed the MMPI-3 in a candid and open fashion . . . . He did acknowledge elevated levels of stress in the top 4% and worry in the top 7%. Situational anxiety was in the top 6%. His main depression scale was within the

[11] According to the psychiatrist consulted to interpret the PEth result:

> PEth is not a normal body metabolite. PEth accumulates when ethanol binds to the red blood cell membrane. PEth reflects the amount of alcohol consumed over the previous 28-30 days as red blood cells degrade and enzymatic action removes PEth. PEth exceeding 20 ng/mL is evidence of "moderate to heavy alcohol consumption."

Ex. 8 at 46–47.

> expected and average range. He is shy and socially avoidant with a negative outlook on the future.

Id. at 40.

The Individual's PEth result was positive at 622 ng/mL. *Id.* at 40–41, 46–48. The Report noted (1) that "PEth exceeding 20 ng/mL is evidence of 'moderate to heavy [ ] consumption'"; (2) that "[r]esearch criteria indicates" that his PEth result "lies numerically between 5 drinks[ ] . . . and 7 drinks[ ] [per] day"—consistent with his self-reported consumption of alcohol; and (3) that "250 ng/mL or higher is the threshold to identify alcohol-dependent subjects needing detox treatment." *Id.* at 41.

In his Report, the DOE Psychologist concluded that the Individual habitually or binge consumed alcohol to the point of impairment. *Id.* at 41. The DOE Psychologist also concluded that the Individual met sufficient *DSM-5-TR* criteria for diagnoses of (1) Substance Use Disorder, without adequate evidence of rehabilitation or reformation; (2) Major Depression; and (3) Generalized Anxiety Disorder. *Id.* at 41–42. The DOE Psychologist found that Major Depression and Generalized Anxiety Disorder (mood disorders) "could facilitate increased alcohol intake as a self-medicating strategy." *Id.* at 42.

The DOE Psychologist recommended that the Individual do the following to begin reforming his alcohol use and eventually rehabilitate himself: (1) "[The Individual] should not drink alcohol again"; (2) "He should participate in a substance abuse treatment program from a licensed provider knowledgeable in this area of practice" and "should attend sessions weekly for a period of 16 weeks"; (3) "He should then attend maintenance/relapse prevention group therapy sessions at least twice a month for three months and then monthly for the remainder of one year"; (4) "He should attend support group meetings such as Alcoholics Anonymous, Rational Recovery or S[MART] Recovery . . ."; and (5) "He should take medication as prescribed by his psychiatrist." *Id.* at 41–42. To address his mood disorders, the DOE Psychologist recommended that the Individual (1) "comply with medication as prescribed and attend appointments with his psychiatrist as directed by the psychiatrist" and (2) "participate in therapy on a weekly basis individually with a licensed therapist familiar with the diagnoses being treated." *Id.* at 42.

During the hearing, the DOE Psychologist provided his expert testimony and opinion after hearing the testimony of the Individual and other witnesses. Tr. at 91–119. He explained that he recommended that the Individual stop drinking because (1) the Individual had "consumed alcohol [at] a problematic level"; (2) the Individual "was depressed"; and (3) "[a]lcohol, while used as a coping response, makes depression worse" since "[i]t's a central nervous system depressant." *Id.* at 96. Because the Individual testified he continued to drink albeit at lessened levels, the DOE Psychologist concluded that he had not complied with this recommendation. *Id.* at 97.

With respect to the Individual's testimony on his psychiatrist's plan, the DOE Psychologist testified that he was "surprised that his psychiatrist, seven months later, still did not have a written treatment plan in place . . . to decrease the alcohol use to zero, or . . . perhaps rare use of alcohol" and that seven months "seemed liked an awfully long time to let it go on with no specific date in place . . . ." *Id.* at 96. When asked if it was common to have a treatment plan that involved a gradual decrease of alcohol over a long-term period like seven months, the DOE Psychologist stated that he had "never seen that." *Id.* at 97. On cross examination, the DOE Psychologist was asked whether

a treating clinician might recommend continued drinking to prevent relapse in the long term; the DOE Psychologist opined that "[i]t seemed odd . . . that someone would prescribe continued drinking as a way of avoiding relapse." *Id.* at 109. The DOE Psychologist also opined that, if the Individual medically detoxed at a hospital in July 2024, then "there would be no reason for him to continue drinking and there would be no reason for a psychiatrist to recommend him to continue drinking." *Id.* at 118. The DOE Psychologist provided that even alcoholics who needed to be "medically detoxed under medical supervision" would have their alcohol consumption decreased "over days or weeks, not months." *Id.* at 97.

The DOE Psychologist also explained that he recommended that the Individual attend a substance abuse treatment program with a licensed provider knowledgeable in substance abuse treatment, since unlicensed providers or those not specialized in substance abuse typically have less success with patients with substance abuse issues. *Id.* at 98. He explained that a 16-week substance abuse treatment program would maintain evidence of progress and difficulties throughout the treatment process. *Id.* at 98. He also reiterated that he recommended aftercare for the remainder of the year so that the Individual would "go through all the holidays, the birthdays, the sentimental dates, [and] celebrations without having alcohol . . . ." *Id.* at 98–99. The DOE Psychologist further explained that he recommended the substance abuse treatment program and aftercare in addition to the Individual seeing a psychiatrist because psychiatrists only "generally provide medication management services[,]" whereas therapists meet with patients for weekly sessions over 45-to-60-minute periods. *Id.* at 99, 104. Regarding the Individual's testimony that he had only discussed therapy with his own psychiatrist, the DOE Psychologist again expressed he was "surprised" that "there ha[d] [not] been a push for therapy . . . ." *Id.* at 100.

The DOE Psychologist explained that he had also recommended the Individual's participation in mutual support groups like SMART Recovery because it would provide a support network of others who have first-hand experience with addiction. *Id.* at 101. The DOE Psychologist confirmed that the Individual had substantially complied with this recommendation. *Id.* at 102. However, the DOE Psychologist made clear that SMART Recovery and other mutual support groups were not replacements for actual group therapy since "[t]here is no licensed person" or "therapy taking place, as defined by state statutes." *Id.* at 100.

Regarding his recommendation that the Individual comply with his medications as prescribed by his psychiatrist, the DOE Psychologist noted that the Individual reported complying with the medications prescribed to him. *Id.* at 102–03. However, he noted that no documentary evidence corroborated this. *Id.*

The DOE Psychologist also explained that he recommended, in addition to taking medications as prescribed, that the Individual attend therapy to address his mood disorders. *Id.* at 103. The DOE Psychologist explained that therapists typically meet with patients on a weekly basis for 45-to-60 minutes. *Id.* at 104. The DOE Psychologist observed that the Individual had not specified the length of his sessions with psychiatrist; that they only met every six weeks; and that the psychiatrist was not "really someone who is there week to week, addressing and making progress on specific areas and not documenting in a written treatment plan . . . ." *Id.* Ultimately, the DOE Psychologist opined that the Individual had not complied with this recommendation. *Id.*

The DOE Psychologist opined that it was positive that the Individual appeared willing to take his medication as prescribed, to continue seeing his psychiatrist, and to continue attending SMART

Recovery sessions. *Id.* at 105. However, the DOE Psychologist noted that, without corroborating evidence of the recommendations of the Individual's psychiatrist, much of the Individual's testimony "appear[ed] to be rationalization . . . , rather than a commitment to improve mental health and abstinence." *Id.* at 106. The DOE Psychologist also found that the "fact that [the Individual] was intoxicated this month" meant "that there [were] still significant problems" and "still significant need for intervention or treatment . . . ." *Id.* at 111. The DOE Psychologist gave a "guarded" prognosis for the Individual, opined that the Individual had not demonstrated rehabilitation or reformation from alcohol misuse, and observed that the Individual had not "follow[ed] through with recommendations . . . made to improve his situation with the mood disorders . . . ." *Id.* at 105–06.

V. ANALYSIS

a. Guideline G

An individual may be able to mitigate security concerns under Guideline G though 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 judgment;

b) The individual acknowledges his maladaptive alcohol use, provides evidence of actions taken to overcome this problem, and has demonstrated a clear and established pattern of modified alcohol 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 demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations.

Adjudicative Guidelines at ¶ 23.

I first must address the Individual's testimony that his psychiatrist instructed him to not quit alcohol "cold turkey" in stark contrast with the DOE Psychologist's recommendation of abstinence. The Individual expressed that he now drank significantly less, no longer drank alcohol to cope with his mood disorders, and will not "abuse" alcohol. However, the Individual provided no corroborating evidence—not even a written statement from his psychiatrist—that modified alcohol consumption was in accordance with his psychiatrist's treatment plan. The DOE Psychologist also noted that various aspects of the Individual's testimony regarding the psychiatrist's recommendations were "surprising"—in particular, that a treating clinician would recommend that a patient wean off alcohol use over a seven-month period without a specific end date in mind. Ultimately, I cannot credit the Individual's self-serving hearsay that his psychiatrist

purportedly recommended that he continue with modified alcohol consumption despite his substance use disorder.

Regarding mitigating condition (a), the Individual cannot demonstrate that the problematic alcohol use giving rise to the security concern occurred so far in the past, infrequently, or under such unusual circumstances. The January 22, 2024, incident precipitating his evaluation by the DOE Psychologist occurred less than a year ago—which is not "so long ago." Furthermore, the DOE Psychologist recommended that he might demonstrate rehabilitation or reformation by abstaining from alcohol use. The Individual admitted to drinking within eight days of the hearing. Even if I were to credit that his psychiatrist recommended reduced alcohol use—which I do not—the Individual's Significant Other testified to witnessing him drink to the point of intoxication within a month of the hearing.

I also cannot conclude that the Individual's problematic alcohol consumption occurred infrequently. The Individual testified that his problematic alcohol consumption began during the COVID-19 pandemic in around 2021, underwent a "gradual ramp" up into 2024—at which point, he was drinking about half of a 750-mL bottle of 80-proof whiskey per day, most days per week. While he and his Significant Other testified that he now drinks less, he continues to drink despite the DOE Psychologist's recommendations and provided no documentary evidence corroborating this purported lessened drinking. Accordingly, I cannot find the problematic alcohol consumption infrequent.

Last, I cannot conclude that his problematic alcohol consumption occurred under unusual circumstances. The Individual indicated that his problematic alcohol usage typically occurred when drinking alone in his apartment and as a response to his anxiety. Being alone in his apartment is a rather ordinary circumstance, and he continues to drink alone in his apartment given his Significant Other's testimony that she observed a bottle or can in his apartment up to a few weeks prior to the hearing. The Individual also drank in response to his mood disorders, triggered by stressors. In particular, the Individual testified that work, not being able to see family over the holidays, and social anxiety triggered the January 22, 2024, incident. While I am sympathetic to his aforementioned struggles, I have no evidence demonstrating that these types of stressors triggering his mood disorders and drinking were unusual. For the above reasons, mitigating condition (a) does not apply.

Regarding mitigating condition (b), the Individual has acknowledged his alcohol use was problematic to an extent. However, the Individual continues drinking alcohol and signed a pledge that to him means that he can continue drinking alcohol, in contravention of the recommendations provided by the DOE Psychologist. The Individual testified that his treating psychiatrist had recommended modified consumption; however, as stated before, he provided no corroborating evidence, and I found this testimony unreliable. Accordingly, mitigating condition (b) does not apply.

Regarding mitigating conditions (c) and (d), the Individual testified that he receives treatment from his psychiatrist. However, I have no specific evidence that the Individual receives counseling or treatment from a substance abuse treatment program. The DOE Psychologist explained the importance of the Individual receiving specialized substance abuse treatment and that a typical psychiatrist provides medication management rather than therapy. Even if I were to credit the Individual's testimony regarding his treatment with his psychiatrist—again, which I do not—the

Individual's own testimony hardly supports that he has made satisfactory progress. I weigh heavily that the Individual expressed that his goal was abstinence but that he was still drinking after seven months with no projected date for achieving that goal. Furthermore, while the Individual has expressed interest in finding a therapist specialized in substance abuse and enrolling in a substance abuse treatment program, as of the date of the hearing, he had not actually done so. Accordingly, mitigating condition (c) does not apply. Similarly, mitigating condition (d) does not apply, since I have no evidence that the Individual has completed any treatment program. For the aforementioned reasons, none of the mitigating conditions are applicable and the Individual has not resolved the security concerns asserted by the LSO under Guideline G.

b. Guideline I

Conditions that could mitigate security concerns under Guideline I include:

(a) the identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan;

(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;

(c) [a] recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by, the U.S. Government [indicates] 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.

Id. at ¶ 29.

Regarding mitigating conditions (a) and (b), the Individual has testified that he is medication compliant, that he attends sessions every six weeks with his psychiatrist, and that he attends SMART Recovery, which assists him with coping mechanisms and identifying triggers. However, he has not put forth evidence, aside from self-serving hearsay, that this is in fact the treatment plan of his psychiatrist. I also lack a prognosis from his psychiatrist. The record does include the DOE Psychologist's treatment plan, which recommended therapy for his mood disorders. Because the Individual admitted he had not yet started therapy, the DOE Psychologist concluded that the Individual had not satisfied his recommendations with respect to his mood disorders. Based on this record—lacking (1) at the very least documentation of the psychiatrist's treatment plan, (2) a prognosis from his psychiatrist, and (3) attendance in therapy as recommended by the DOE Psychologist's treatment plan—I cannot find that mitigating conditions (a) or (b) are satisfied.

Regarding mitigating condition (c), I have no testimony from a duly qualified mental health professional that the Individual has a condition in control or in remission with a low probability of

recurrence or exacerbation. As stated above, the DOE Psychologist testified that the Individual had not demonstrated reformation. Mitigating condition (c) does not apply.

Regarding mitigating conditions (d) and (e), there is no dispute that the Individual has been diagnosed with mood disorders for which he is currently receiving treatment from his psychiatrist. However, as stated above, the Individual has not followed through on the recommendations of the DOE Psychologist to improve his mood disorders, specifically attending therapy. Furthermore, the DOE Psychologist explained that his mood disorders could facilitate increased drinking and that alcohol, as a depressant, would exacerbate his mood disorders. Regardless, the Individual continued consuming alcohol up until eight days before the hearing. Thus, despite the Individual's treatment from his psychiatrist, his behavior poses a risk of exacerbating his mood disorders such that they could impair his judgment and reliability. Accordingly, it cannot be said that the conditions were "temporary" or not "current." Mitigating conditions (d) and (e) do not apply.

VI. CONCLUSION

In the above analysis, I found that there was sufficient derogatory information in the possession of DOE to raise security concerns under Guidelines G and I of the Adjudicative Guidelines. After considering all the relevant information, both favorable and unfavorable, in a comprehensive, common-sense manner, including weighing all the testimony and other evidence presented at the hearing, I find that the Individual has not brought forth sufficient evidence to resolve the security concerns set forth in the Summary of Security Concerns. Accordingly, I have determined that the Individual's access authorization should not be restored. This Decision may be appealed in accordance with the procedures set forth at 10 C.F.R. § 710.28.

Janet R. H. Fishman
Administrative Judge
Office of Hearings and Appeals