*The original of this document contains information which is subject to withholding from disclosure under 5 U.S. C. § 552. Such material has been deleted from this copy and replaced with XXXXXX's.

United States Department of Energy
Office of Hearings and Appeals

In the Matter of:	Personnel Security Hearing	)	
		)	
Filing Date:	April 17, 2025	)	Case No.: PSH-25-0105
		)	
		)	

Issued: September 18, 2025

Administrative Judge Decision

Diane L. Miles, Administrative Judge:

This Decision concerns the eligibility of XXXXXX (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.* (June 8, 2017) (Adjudicative Guidelines), I conclude that the Individual's access authorization should not be granted.

I. Background

The Individual is an applicant for employment with a DOE contractor, for a position that would require him to hold a security clearance. After reviewing the results of a background investigation, including the Individual's responses during a March 2024 Enhanced Subject Interview (ESI), and the Individual's medical records, the DOE discovered derogatory information regarding the Individual's alcohol use and misuse of prescription medication, including a 2007 alcohol-related arrest and a 2018 drug-related arrest. Exhibit (Ex.) 7; Ex. 11 at 257–62.[2]

In October 2024, the Local Security Office (LSO) issued a Letter of Interrogatory (LOI) to the Individual, which sought details about his alcohol consumption, his misuse of prescription medication, and his arrests. Ex. 6. In December 2024, the LSO referred the Individual for an evaluation by a DOE-contractor psychiatrist (DOE Psychiatrist), who conducted a clinical interview of the Individual and issued a report (the Report) of her findings. Ex. 8. Based on her evaluation of the Individual, the DOE Psychiatrist opined that the Individual met sufficient

[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 exhibits submitted by the DOE were Bates numbered in the upper right corner of each page. This Decision will refer to the Bates numbering when citing to exhibits submitted by the DOE.

diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*) for a diagnosis of Alcohol Use Disorder (AUD), Severe, without adequate evidence of rehabilitation or reformation. Ex. 8 at 144. The DOE Psychiatrist also opined that the Individual met sufficient *DSM-5-TR* criteria for a diagnosis of Opiate Use Disorder (OUD), Severe, Sustained Remission, without adequate evidence of rehabilitation or reformation. *Id*.

Due to unresolved security concerns raised by the Individual's drug and alcohol use, the LSO informed the Individual, in a Notification Letter, that it possessed reliable information that created substantial doubt regarding his eligibility to hold a security clearance. Ex. 1 at 8–10. In a Summary of Security Concerns (SSC) attached to the Notification Letter, the LSO explained that the derogatory information raised security concerns under Guideline G (Alcohol Consumption) and Guideline H (Drug Involvement and Substance Misuse) of the Adjudicative Guidelines. *Id*. at 6–7.

In April 2025, the Individual requested an administrative hearing, and the LSO forwarded the Individual's request to the Office of Hearings and Appeals (OHA). Ex. 2. The Director of OHA appointed me as the Administrative Judge in this matter. At the hearing I convened pursuant to 10 C.F.R. § 710.25(d), (e), and (g), I took testimony from three witnesses: the Individual, the Individual's wife, and the DOE Psychiatrist. *See* Transcript of Hearing, OHA Case No. PSH-25-0105 (Tr.). Counsel for the DOE submitted eleven exhibits, marked as Exhibits 1 through 11. The Individual submitted eleven exhibits, marked as Exhibits A through K.

II. The Summary of Security Concerns

A. Guideline G (Alcohol Consumption)

Under Guideline G of the Adjudicative Guidelines, "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. Conditions that could raise a security concern under Guideline G include: "alcohol-related incidents away from work, such as driving while under the influence . . . or other incidents of concern . . . ," "habitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed with alcohol use disorder," and a "diagnosis by a duly qualified medical or mental health professional (e.g., physician, clinical psychologist, psychiatrist, or licensed clinical social worker) of alcohol use disorder." *Id*. at ¶ 22(a), (c)–(d). In invoking Guideline G, the LSO cited the following information:

A. On July 15, 2007, the Individual was arrested for Intoxication. During the December 2024 psychiatric evaluation, the Individual admitted that, before this arrest, he consumed a six pack of beer;

B. During the December 2024 psychiatric evaluation, the Individual admitted that from 2020 to 2023, he would consume a quarter of a pint of whiskey daily, and sometimes he would consume more than a quarter of a pint;

C. During the December 2024 psychiatric evaluation, the Individual reported that in May 2024, he went to the emergency room and complained of abdominal pain. He

admitted that while sitting in a waiting room, he drank whiskey to manage his abdominal pain;

D. During the December 2024 psychiatric evaluation, the Individual reported that his current alcohol consumption was "one to two beers a couple of times a week and a shot of 40% proof whiskey less than once a week." He also admitted that the night before the psychiatric evaluation, he consumed "one beer, and a half shot of 40% proof whiskey"[3]; and

E. In December 2024, the DOE Psychiatrist opined that the Individual met sufficient *DSM-5-TR* diagnostic criteria for a diagnosis of AUD, Severe, without adequate evidence of rehabilitation or reformation.

Ex. 1 at 6.

B. Guideline H (Drug Involvement and Substance Misuse)

Under Guideline H of the Adjudicative Guidelines, the illegal use of controlled substances, including "the misuse of prescription and non-prescription drugs," "can raise questions about an individual's reliability and trustworthiness, both because such behavior may lead to physical or psychological impairment and because it raises questions about a person's ability or willingness to comply with laws, rules, and regulations." Adjudicative Guidelines at ¶ 24. Conditions that could raise a security concern under Guideline H include "any substance misuse" and a "diagnosis by a duly qualified medical or mental health professional (e.g., physician, clinical psychologist, psychiatrist, or licensed clinical social worker) of substance use disorder." *Id.* at ¶ 25(a), (d).

In invoking Guideline H, the LSO cited the following information:

A. In October 2018, the Individual was arrested and charged with Driving Under the Influence (DUI) of Xanax. In his LOI, the Individual admitted that before this arrest, he consumed "several Xanax, not prescribed to him, causing him to fall asleep and cause a multi-car accident";

B. Medical records dated December 2020 reflect that, during that month, the Individual was diagnosed with OUD by his medical provider;

C. During his March 2024 ESI, the Individual stated that in 2005, he was prescribed oxycodone for pain. He admitted that from December 2005 until November 2020, "his use of oxycodone evolved into misuse in which he consumed oxycodone three times per day, daily";

D. During the December 2024 psychiatric evaluation, the Individual admitted that a couple of months prior to his psychiatric evaluation, he found a few pills of oxycodone in his garage and consumed them; and

[3] Although the Individual's reported pattern of alcohol consumption informed the DOE Psychiatrist's opinion, it does not present a discrete security concern.

E. In December 2024, the DOE Psychiatrist opined that the Individual met sufficient *DSM-5-TR* diagnostic criteria for a diagnosis of OUD, Severe, Sustained Remission, without adequate evidence of rehabilitation or reformation.

Ex. 1 at 6–7.

Considering the conduct described above, I find the LSO's invocation of Guidelines G and H of the Adjudicative Guidelines to be justified.

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 Department 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 their 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

The Individual's Alcohol Consumption

In July 2007, the Individual was arrested for being intoxicated. Ex. 5 at 30; Ex. 8 at 137. The Individual was not driving at the time of his arrest, but he did consume "about a six pack of beer" before the arrest. Ex. 8 at 137. He was taken to a detention center to detox and was later released without being charged with a crime. Ex. 5 at 30; Ex. 11 at 281. In 2020, the Individual stopped drinking alcohol for a period, but, at some time later in 2020, after he resumed drinking, he would consume a quarter-pint, or more, of whiskey, daily. Ex. 8 at 137.

In the October 2024 LOI, the Individual reported that during July 2023, he consumed two or more alcoholic drinks, three times a week. Ex. 6 at 45. During this month, the Individual voluntarily sought alcohol counseling from his employer's occupational health department, after he experienced symptoms of alcohol withdrawal while at work. Ex. 11 at 260–61; Ex. 6 at 45. From July 2023 to September 2023, the Individual attended alcohol counseling once every two to three weeks. Ex. 11 at 261. His treatment included group counseling sessions, alcohol education, and

the use of prescribed alcohol cessation medication. Ex. 6 at 41–42; Ex. 11 at 261. The Individual was not provided with a diagnosis during the program. Ex. 4 at 25. After completing alcohol counseling, the Individual continued to consume alcohol. Ex. 11 at 261. He avoided drinking whiskey because it caused him to have "stronger reactions" than other types of alcoholic beverages did. *Id*. Instead, he would drink beer and claimed during the ESI that he consumed "approximately 2–3 beers on a given occasion." *Id*.

During the March 2024 ESI, the Individual stated that his current alcohol consumption was "two beers, three times a week." Ex. 11 at 260. He also stated that alcohol had never "never caused a negative impact on his life in any way." *Id*. at 261. In the October 2024 LOI, the Individual reported to the LSO that he knew alcohol could affect a person's judgment, but he did not let alcohol control him. Ex. 6 at 47. He reported that he did not have a problem with alcohol, he "just like[d] the taste of beer," and he could control his alcohol consumption. *Id*. at 47–48.

During the December 2024 psychiatric evaluation, the Individual told the DOE Psychiatrist that in May 2024, he drank whiskey while waiting in a hospital waiting room for treatment for abdominal pain. Ex. 8 at 137. During the May 2024 hospital visit, the Individual was prescribed medication for alcohol withdrawal symptoms. *Id.* He told the DOE Psychiatrist that he did not believe he had a problem with alcohol, but that his family was "pushing him to quit" and he was "thinking about quitting alcohol." *Id.* The Individual told the DOE Psychiatrist that he believed he could quit drinking alcohol on his own. *Id*. At this time, he reported consuming "1 to 2 beers … a couple times a week," and a shot of 40% proof whiskey "every once in a while," which he later clarified to "less than once a week." *Id*. The Individual reported that, the day before the evaluation, he consumed "one beer and half a shot (40 proof)," and two days before the evaluation, he consumed one beer. *Id*. at 140. As part of the psychiatric evaluation, on December 23, 2024, the Individual underwent Phosphatidylethanol (PEth)[4] testing, the result of which was positive, at a level of 102 ng/mL. *Id*. at 147. The DOE Psychiatrist found that if the Individual had consumed one to two beers, a couple of times per week, and a shot of alcohol "less than once per week," during the past 30 days, he would not have had a positive PEth test result. *Id.* at 137. The DOE Psychiatrist found that the result of the Individual's PEth test was "evidence of at least moderate drinking," not consistent with his reported alcohol consumption within the prior 30 days, and that he was likely underreporting his alcohol intake. *Id*. at 137, 140.

The DOE Psychiatrist diagnosed the Individual with AUD, Severe, without adequate evidence of rehabilitation or reformation. Ex. 8 at 144. She believed that the Individual had minimal insight into his issues with alcohol, that he minimized the impact alcohol has had on his life, and that he normalized his episodes of withdrawal. *Id*. at 142. To show adequate evidence of rehabilitation or reformation from his AUD, Severe, the DOE Psychiatrist recommended that the Individual abstain from alcohol for 12 months, supported by monthly PEth testing. *Id*. at 144. She also recommended that the Individual obtain and work with a therapist, at least weekly, for a minimum of six months, to gain insight into his alcohol use, and attend Alcoholics Anonymous (AA) or SMART Recovery at least three times a week. *Id*.

[4] The Report indicates that to have a positive PEth test result, "one must drink more than two drinks a day for the past 30 days, have more than four drinks twice a week or more, or consume four drinks or more within 1-2 days of the test." Ex. 8 at 137. A PEth level exceeding 20 ng/mL is evidence of "moderate to heavy ethanol consumption." *Id*. at 147.

The Individual's Misuse of Prescription Medication

Since the 1990s, the Individual has used prescription pain medication, specifically opioids, to manage chronic pain he suffered from work-related injuries and degenerative joint disease. Ex. 8 at 137. In 2005, he was prescribed oxycodone to treat his pain, and by December 2005, he was misusing the medication. Ex. 11 at 260. The Individual would take oxycodone more often than prescribed, and he would run out of the medication early, which caused him to experience withdrawal symptoms. *Id*.

In October 2018, the Individual was arrested for DUI of Xanax. Ex. 11 at 259; Ex. 10 at 185. Before the arrest, the Individual received Xanax from a friend and took the drug while driving his car. Ex. 11 at 259. The Xanax made the Individual feel "very sleepy," and he got into a car accident, hitting two vehicles in oncoming traffic. *Id*. After this arrest, the Individual was required to attend DUI courses at a county drug and alcohol program, and he was required to have an ignition interlock device installed in his car. *Id*. From September 2019 to December 2019, the Individual received treatment from a county drug and alcohol program. *Id.* at 277. The program consisted of three "psychoeducational groups" and one individual therapy session, weekly, for 12 weeks. *Id.* The Individual successfully completed the program and was discharged, but his misuse of prescription medication continued. *Id*.

In November 2020, the Individual tried to stop misusing oxycodone on his own, without using a drug program. Ex. 11 at 258. While detoxing, the Individual had a "nervous/psychotic breakdown," after which he was arrested and involuntarily hospitalized for two weeks. Ex. 8 at 138; Ex. 11 at 279. The Individual was sentenced to 36 months of probation, the terms of which required him to enroll in a drug treatment program. Ex. 11 at 258. In December 2020, the Individual was seen by his medical provider, during which he reported that he was consuming benzodiazepines[5] to alleviate his feelings of anxiety. Ex. 7 at 87. He also reported that the benzodiazepines were not prescribed to him, and that he "got them off the street." *Id*. The Individual's medical provider diagnosed him with OUD and enrolled him in a drug treatment program, during which he was prescribed suboxone to treat his OUD. *Id.* at 83, 87–88; Ex. 6 at 39–40. The Individual's medical provider advised the Individual to avoid alcohol. Ex. 7 at 88–89. During the March 2024 ESI, the Individual reported that from 2005 to 2020, he was consuming oxycodone pills three times a day. Ex. 11 at 260. He told the investigator he did not intend to misuse any prescription drugs in the future. *Id*.

During his December 2024 psychiatric evaluation, the Individual told the DOE Psychiatrist that a few months before the evaluation, he found a few pills of oxycodone in his garage and took them. Ex. 8 at 138. When the DOE Psychiatrist asked the Individual why he took the oxycodone, he replied, "I don't know." *Id*. Before his use of oxycodone he found in his garage, he reported that his last use of opioids was in December 2020, when he met with his medical provider. *Id*. As part of the psychiatric evaluation, the Individual underwent a urine drug screen (UDS)[6], the result of

[5] During the hearing, the DOE Psychiatrist explained that benzodiazepine is a type of opioid medication that is used to treat alcohol withdrawal. Tr. at 58.

[6] The DOE Psychiatrist's Report indicates that a UDS tests a person's urine for evidence of alcohol consumed within the past 12 hours, amphetamine, methamphetamine, cocaine, marijuana, opiates, and phencyclideine. Ex. 8 at 140. During the hearing, the DOE Psychiatrist testified that, related to alcohol consumption, a UDS differs from a PEth test in that a PEth test would show evidence of alcohol consumption during the past 21 to 28 days. Tr. at 57.

which was negative for the presence of drugs. *Id*. at 140. The DOE Psychiatrist diagnosed the Individual with OUD, Severe, in sustained remission. *Id*. at 144.[7] To achieve rehabilitation or reformation from his OUD, the DOE Psychiatrist recommended that the Individual be monitored for drug use, through random UDSs, for a minimum of 12 months. *Id*. Because the Individual had a history of misusing benzodiazepines, she explained that "while [the Individual] works toward his sobriety, he is at risk of illicit use of benzodiazepines, as they stimulate the same receptors in the brain"; therefore, she recommended that the Individual also be monitored for misuse of benzodiazepines, which the random UDSs she recommended to monitor the Individual's abstinence from opioids would also detect. *Id*.

Hearing Testimony

During the hearing, the Individual's wife testified that she had been married to the Individual for the past 40 years. Tr. at 10. She claimed that she was not familiar with much of the Individual's history of drug use because she was busy working outside of the home during the day and caring for her parents and children during the evenings. *Id*. at 10, 12. She also claimed to not be familiar with the Individual's medical history, but she knew he was prescribed medication, such as oxycontin and oxycodone. *Id*. at 10–11. The Individual told her that he began a suboxone program at a local hospital, but the two of them did not discuss the details of the program. *Id*. at 14. She knew the Individual attended a county drug and alcohol program, but she was not aware of any details of his treatment. *Id*. at 20. She last saw him drink alcohol in June 2025, during which he would drink "a beer here and there." *Id*. at 15. She has not seen the Individual buy alcohol or bring any alcohol home, since June 2025. *Id*. at 15–16.

During the hearing, the Individual testified that he had previously used prescribed opioid medication from the 1990s through 2020. Tr. at 28. He admitted that he has a history of misusing his opioid medication; he would take more than his prescribed dosage of oxycodone, and then he would consume alcohol when he ran out of the drug. *Id*. at 30. The Individual did not recall the details of the treatment he received from the county drug and alcohol program he attended in 2019. *Id*. at 31. He claimed that he stopped drinking alcohol for a period, before he entered the county drug and alcohol program, because he still had an ignition interlock device installed in his car from his October 2018 arrest for DUI and he had to pass a breath alcohol test before he could drive. *Id*. He explained that in May 2024, he was experiencing abdominal pain and went to a hospital to obtain treatment. *Id*. at 27. He admitted that he drank alcohol to help ease his pain while he waited to be seen by a doctor, but he claimed that he did not consume whiskey while in the waiting room. *Id*. He stated that he drank the whiskey on his way to the hospital, and he left the waiting room, went to his vehicle, and "drank a little more." *Id*. He stated that the doctor who evaluated him for abdominal pain recommended that he stop drinking alcohol. *Id*. at 28.

The Individual further testified that he stopped drinking alcohol in June 2025. Tr. at 37, 41. He could not explain why he didn't stop drinking after he received the DOE Psychiatrist's Report, other than that he likes the way alcohol tastes. *Id*. at 37. He did not follow the DOE Psychiatrist's recommendation to see a therapist and enroll in an alcohol treatment program, such as AA. *Id*. at

[7] The DOE Psychiatrist characterized the Individual's consumption of oxycodone pills he found in his garage, a few months before his evaluation, as a "slip" and "a lapse, rather than a relapse." Ex. 8 at 143–44; Tr. at 49. She explained that "[s]uch lapses, while high-risk and warranting close monitoring, are not uncommon in substance use disorder[s] and do not necessarily indicate a break in remission." Ex. 8 at 144.

38–39. He claimed that he contacted his employer about receiving counseling services, but he did not enroll in a program. *Id*. at 38–39, 41–42. The Individual believed that he could rely on his willpower to avoid consuming alcohol in the future, and he believed that he can "live without it." *Id*. at 41, 45. As for alcohol testing, the Individual underwent PEth testing in July 2025, the result of which was negative for the presence of alcohol. *Id.* at 39; Ex. K. He also claimed that he was tested for drugs and alcohol in June 2025, after he was involved in a workplace accident, and the result of that test was negative. Tr. at 39–40.

As for his misuse of opioids, the Individual acknowledged that his misuse was "definitely a problem." He stated that he had "suffered a lot" with the drugs and that since he completed the suboxone program, he no longer needs oxycodone.[8] Tr. at 42, 44–46. He explained that he had used topical medication, injectable medication, over the counter pain medication, and other non-narcotic drugs to help him relieve his joint pain since discontinuing opioid use. *Id*. at 34–35, 46. He also stated that if his pain worsens, despite his use of injectable pain medication, he will consider getting surgery. *Id*. at 42. He submitted copies of hospital bills, indicating that between October 2024 and May 2025, he had received cortisone injections, monthly. Ex. A–J. He also explained that he had not taken any oxycodone between 2020 and when he took the oxycodone pills he found in his garage, because he had not been prescribed any oxycodone since then. Tr. at 33–34.

After listening to the testimony provided during the hearing and reviewing the Individual's exhibits, the DOE Psychiatrist opined that the Individual had not demonstrated reformation or rehabilitation from his OUD, Severe, or his AUD, Severe. Tr. at 54–55. She explained that it would be very easy for the Individual to slide from one addiction to another, especially if he did not have the support of an active treatment program. *Id*. at 50–51. Although the Individual testified that he stopped drinking in June 2025, and he produced a negative July 2025 PEth test, he did not follow her recommendation to enroll in alcohol counseling or an alcohol treatment program. *Id*. at 55. She also explained that although the Individual had a history of completing DUI classes and a county drug and alcohol program, those programs do not provide the "individual therapy" and the "deep dive" the Individual needs to address his triggers to drink. *Id*. at 58–59. She stated that without the use of a therapist, the Individual would not be able to gain insight into why he is drinking. *Id*. As for a prognosis with regard to his AUD, using a scale of 1 to 5, with 5 being the "absolute best … multiple years clean, not dealing with other issues," she gave the Individual a prognosis of 2. *Id*. at 55, 60.

As for the Individual's OUD, the DOE Psychiatrist explained that although she would have liked to see laboratory evidence to support the Individual's testimony that he was no longer misusing opioids, it was positive that he testified to not having misused any drugs since his consumption of oxycodone pills he found in his garage a few months before his December 2024 evaluation, and that he testified that he would consider using surgery to relieve his pain, rather than prescription medication. Tr. at 54. Her prognosis for the Individual's OUD was "good." *Id*. at 55, 60. When asked to opine as to the Individual's belief that he can avoid alcohol and misusing opioids using his willpower alone, she explained that studies have shown that only, in exceptional circumstances, can a person "cold knuckle through a substance use disorder" and opined that, until the Individual

[8] The Individual testified that he "weaned off" the suboxone a few months after he started taking it, and "sooner than they wanted me to." Tr. at 44.

enrolls, and remains in, a treatment and drug monitoring program, he would not figure out the "social and psychiatric underpinnings" behind his behavior. *Id*. at 55–56.

A. Guideline G

The Adjudicative Guidelines provide that conditions that could mitigate security concerns under Guideline G include:

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

Adjudicative Guidelines at ¶ 23.

The Individual has not mitigated the security concerns raised by his alcohol consumption through any of the above-referenced factors under Guideline G of the Adjudicative Guidelines.

Although there are very few details about the Individual's July 2007 arrest for Intoxication, the Individual admitted that before the arrest, he binge-consumed a six-pack of beer, and his pattern of problematic alcohol consumption continued for 18 years since that arrest. He admitted that between 2020 and 2023, he consumed whiskey daily. Since 2023, however, he claimed that he has consumed only one to two beers on a weekly basis along with occasional whiskey shots. The record gives me reason to doubt this representation. Just last year, during a May 2024 hospital visit, he was given medical advice to abstain from alcohol and prescribed medication for alcohol withdrawal symptoms. A few months later, the DOE Psychologist found he was misrepresenting his alcohol consumption based on the elevated results of his PEth test. These factors suggest that the Individual's alcohol consumption has remained heavier than reported, and has continued at this level until as recently as June 2025, two months before the hearing. The Individual did not produce evidence that his pattern of alcohol consumption stemmed from any unusual circumstances. Finally, because the Individual failed to follow the DOE Psychiatrist's recommendation to engage with a therapist to treat his AUD, Severe, and the DOE Psychiatrist opined that the Individual is not yet reformed or rehabilitated from the disorder, I am unable to conclude that his problematic alcohol consumption will not recur. For these reasons, I find the first mitigating condition inapplicable.

Despite the Individual's extensive history of problematic alcohol consumption, he has been unwilling to acknowledge that he had an alcohol problem. During his ESI, he reported that he did not believe that alcohol had negatively impacted his life, despite his arrest for Intoxication in 2007, and despite him experiencing symptoms of alcohol withdrawal at work, which spurred him to enter an alcohol counseling program. He continued to drink after two medical providers advised him to stop doing so, after having been notified by the DOE that there are concerns about his alcohol consumption which may affect his ability to obtain a security clearance, and after the DOE Psychiatrist notified him that he has AUD, Severe. The Individual is in denial as to the extent of his alcohol problem. Therefore, the second mitigating condition is inapplicable.

The Individual also failed to follow the DOE Psychiatrist's recommendation to enroll in an alcohol treatment program and engage with a therapist, so he could receive treatment for his AUD, Severe. He completed two months of alcohol counseling in 2023, and he completed DUI classes and a county drug and alcohol program after his October 2018 arrest. But the Individual continued to drink after each program, and he did not provide details as to the substance of his treatment during either program. As the Individual is not presently in treatment, and has relapsed following previous interventions, I find the third mitigating condition inapplicable.

Considering the severity of the Individual's AUD and his history of alcohol consumption, I am persuaded by the DOE Psychiatrist's opinion that the Individual's brief periods of alcohol treatment in the past were insufficient because they did not include counseling related to his triggers to drink. Finally, although the Individual testified that he stopped drinking in June 2025, and he presented a negative PEth test from July 2025, one month of abstinence is short of the 12 months of abstinence recommended by the DOE Psychiatrist, and he has not demonstrated a clear and established pattern of modified consumption or abstinence from alcohol in accordance with the DOE Psychiatrist's treatment recommendations. I am persuaded by the opinion of the DOE Psychiatrist that the Individual is not yet reformed or rehabilitated from his AUD, Severe, and I find that his problematic alcohol consumption continues to cast doubt on his reliability, trustworthiness, and judgment. Thus, the fourth mitigating condition is inapplicable.

Based on the foregoing analysis, I cannot find that the Individual has resolved the concerns raised by his alcohol consumption under Guideline G of the Adjudicative Guidelines.

B. Guideline H

The Adjudicative Guidelines provide that conditions that could mitigate security concerns under Guideline H include:

(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;

(b) The Individual acknowledges his or her drug involvement and substance misuse, provides evidence of actions taken to overcome this problem, and has established a pattern of abstinence, including, but not limited to:

(1) Disassociation from drug-using associates and contacts;
(2) Changing or avoiding the environment where drugs were used; and

(3) Providing a signed statement of intent to abstain from all drug involvement and substance misuse, acknowledging that any future involvement or misuse is grounds for revocation of national security eligibility;

(c) abuse of prescription drugs was after a severe or prolonged illness during which these drugs were prescribed, and abuse has since ended; and

(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.

Adjudicative Guidelines at ¶ 26.

As to factor (a), the Individual's use of prescription opioids began as a means to relieve chronic pain caused by his workplace injuries and his degenerative joint disease. He admitted that beginning in December 2005, he misused his prescription opioids. Although the Individual's misuse began 20 years ago, his behavior developed into a pattern that was frequent and that continued until at least 2024, when he took oxycodone pills he found in his garage. I am unable to conclude that the Individual's misuse of opioids ended in December 2020 because he did not produce any evidence he had not been prescribed opioids between December 2020 and December 2024, and he did not produce evidence of negative drug testing during that period. Finally, the Individual did not follow the DOE Psychiatrist's recommendation to undergo random UDSs, so he could be monitored for misuse of opioids, and the DOE Psychiatrist opined that he is not yet rehabilitated or reformed from his OUD, Severe. The Individual submitted evidence he received pain injections, for eight months, which supports that he still suffers from chronic pain. Without having resolved his OUD, Severe, the Individual is not unlikely to resume misusing opioids to relieve his pain. Therefore, I am unable to conclude that the Individual's misuse of opioids occurred so long ago, was so infrequent, or occurred under such circumstances that it is not likely to recur, and he has not mitigated the security concerns under ¶ 26(a) of the Adjudicative Guidelines.

As to factor (b), the Individual acknowledged his misuse of prescription opioids, but I am unable to conclude that he has taken sufficient actions to overcome his problem. Notably, he has not enrolled in a treatment and drug monitoring program, as recommended by the DOE Psychologist. The Individual has also not established a pattern of abstinence, as explained in the preceding paragraph. Except for the Individual's receipt of Xanax from a friend before his October 2018 arrest for DUI, and his admission to taking benzodiazepines that he got "off the street" in 2020, the Individual's opioids were prescribed by his medical providers. There is no evidence to suggest that the Individual's behavior was influenced by associating with others who were also misusing prescription medication or by him being present in certain environments where drugs were used, and which he would need to avoid. The Individual did not submit a statement of intent to abstain from all drug involvement and substance misuse in the future. But, given his history of misuse and failure to follow the DOE Psychiatrist's recommendation to undergo UDSs, I would not find any written commitment by the Individual to no longer engage in misuse of his prescription opioids to be persuasive. Therefore, the Individual has not mitigated the security concerns under ¶ 26(b) of the Adjudicative Guidelines.

As to factor (c), the Individual has suffered from chronic pain caused by workplace injuries and his degenerative joint disease since the 1990s, and the Individual used prescription opioids to relieve his pain beginning in 2005. The Individual did not submit evidence regarding the severity of his pain. Notwithstanding the Individual's need for pain relief, he admits that he has misused his pain medication. As explained above, the Individual did not follow the DOE Psychiatrist's recommendation to undergo random UDSs to monitor his drug use and he has not yet resolved his OUD, Severe. Given his lengthy history of misuse, and his admission to misusing oxycodone just months before his 2024 evaluation, I do not find the Individual credible as to his claim that he stopped misusing prescription opioids in December 2020, without evidence of laboratory testing. Therefore, I am unable to conclude that his misuse of prescription opioids has ended, and he has not mitigated the security concerns under ¶ 26(c) of the Adjudicative Guidelines.

As to factor (d), after his October 2018 arrest for DUI of Xanax, the Individual completed a three-month county drug and alcohol program. The Individual could not recall, and he did not produce evidence of, the substance of the treatment he received from the program, so it is not known if the treatment he received addressed the issues that may have contributed to his misuse of prescription opioids. In addition, the Individual completed this program to satisfy the terms of his probation from his 2018 arrest, not because he was willing to resolve his drug problem, and indeed his misuse of prescription opioids continued upon completion of the program. Although he participated in a suboxone drug treatment program in December 2020, the Individual only enrolled in the program because the terms of his probation, from his November 2020 arrest, required that he do so. Therefore, I do not find that the Individual has satisfactorily completed a drug treatment program to address his misuse of prescription opioids.

The Individual's testimony, and documentary evidence, that he is using over-the-counter medication and pain-relieving injections to manage his pain, rather than solely relying on prescription opioids, is a positive sign. However, he also admitted to using benzodiazepines to treat his anxiety, and the DOE Psychiatrist cautioned that the Individual needs to be monitored for this drug, via random UDSs, because he is still at risk of misusing this drug. I am also persuaded by the opinion of the DOE Psychiatrist, who opined that, because the Individual was consuming alcohol when he ran out of his opioids, and he has not resolved his AUD, Severe, he is at risk of sliding from one addiction to the other, without treatment. Although the DOE Psychiatrist gave the Individual a good prognosis, she also opined that the Individual is not rehabilitated or reformed from his OUD, Severe. Therefore, his behavior continues to cast doubt on his current reliability, trustworthiness, and good judgment, and he has not mitigated the security concerns under ¶ 26(d) of the Adjudicative Guidelines.

Based on the foregoing analysis, I cannot find that the Individual has resolved the concerns raised by his misuse of prescription opioids and other drug-related conduct under Guideline H of the Adjudicative Guidelines.

V. Conclusion

For the reasons set forth above, I conclude that the LSO properly invoked Guidelines G and H of the Adjudicative Guidelines. After considering all the evidence, 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 Guidelines G and H concerns set forth in the SSC. Accordingly, the

Individual has not demonstrated that granting him a security clearance would not endanger the common defense and security and would be clearly consistent with the national interest. Therefore, I find that the Individual should not be granted access authorization. This Decision may be appealed in accordance with the procedures set forth at 10 C.F.R. § 710.28.

Diane L. Miles
Administrative Judge
Office of Hearings and Appeals