

November 1992

# EMPLOYEE DRUG TESTING

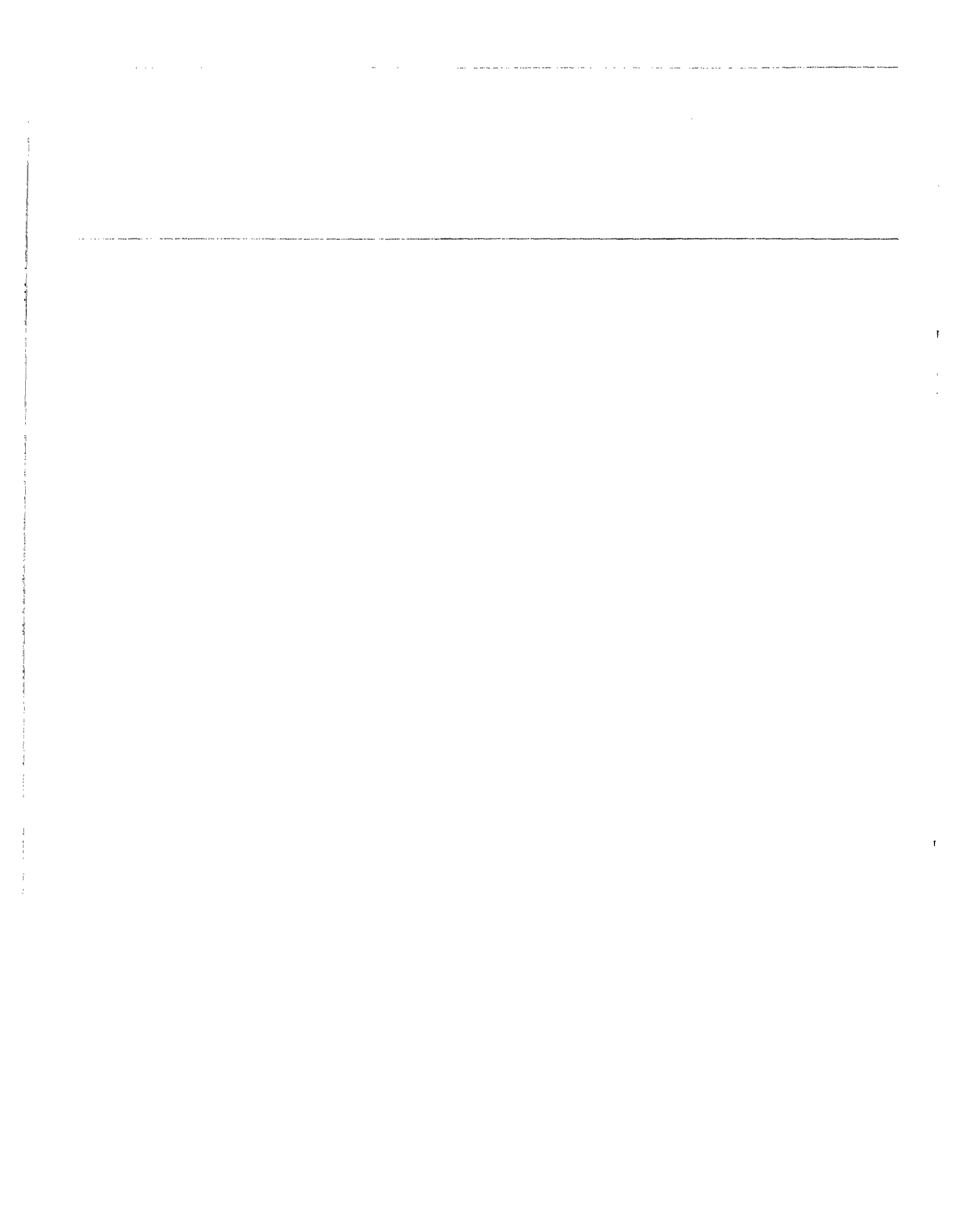
## Opportunities Exist to Lower Drug-Testing Program Costs



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General Government Division

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November 23, 1992

The Honorable Dennis DeConcini  
Chairman, Subcommittee on Treasury,  
Postal Service, and General Government  
Committee on Appropriations  
United States Senate

The Honorable Barbara Mikulski  
United States Senate

Your March 7, 1991, letter asked us to study the costs associated with federal employee drug testing and determine whether the potential for cost savings exist. This report identifies the potential for savings in several drug-testing cost areas.

Background

Executive Order 12564 (Sept. 15, 1986) established the Federal Drug-Free Workplace Program and required the head of each executive branch agency to establish a program for random testing of employees in sensitive positions and for voluntary employee drug testing. In addition, the order authorized testing (1) when there is reasonable suspicion that an employee uses illegal drugs, (2) in an examination authorized by the agency regarding an accident or unsafe practice, (3) as part of or as a follow-up to counseling or rehabilitation for illegal drug use, and (4) when an individual applies for employment with the agency. During the 12-month period ending September 30, 1991, 59 agencies conducted a total of 116,732 employee drug tests. Table 1.1 summarizes the number of tests by type of test and the number of positive test results.

Table 1.1: Profile of Testing Results From October 1990 Through September 1991 (In all 59 agencies)

	Number of persons tested							
	Total	Employees						Applicants
		Total	Reasonable suspicion	Accident related	Randomly selected	Volunteer	Follow-up	Total
Total tested	116,732	64,966	359	130	62,079	808	1,590	51,766
Total verified positive	578	314	54	13	216	1	30	264
Percent positive	0.5%	0.5	15	10	0.3	0.1	2	0.5%

The Office of National Drug Control Policy (ONDCP) was designated in February 1991 as the lead agency for overseeing implementation of Executive Order 12564. In addition, the Department of Health and Human

Services (HHS) was required to provide scientific and technical guidelines that all executive branch agencies are to use in carrying out employee drug tests. Among other things, the HHS guidelines require the agencies to obtain the following specific drug-testing services: a collection of employee urine samples, laboratory analysis of samples, medical reviews of test results, and quality assurance testing to ensure laboratory accuracy. These services make up the direct costs associated with drug testing. On July 11, 1987, the Supplemental Appropriations Act of 1987 (Public Law 100-71) was enacted and, among other things, prohibited the use of appropriated funds for operation of drug testing programs until certain conditions such as adherence to the HHS guidelines were met.

Agencies are to report drug testing costs to HHS, which is to publish them in its Federal Drug-Free Workplace Program Semi-Annual Survey. HHS' two most recent surveys covered the periods October 1990 through March 1991 and April 1991 through September 1991, respectively. The first survey profiled 119 executive branch agencies. It included cost information on 48 of the 51 agencies that tested employees and reported total direct costs of \$3.8 million. The more recent survey profiled the programs of 131 agencies and included direct costs of \$3.8 million for all 59 agencies that tested employees. Together the two surveys reported total direct costs of about \$7.6 million for the 12-month period.

The total direct costs reported in the surveys consisted of approximately \$3 million for the collection of employee samples, \$3.4 million for laboratory analysis, \$0.2 million for the purchase of blind proficiency test samples for the quality assurance programs, and \$1 million for a medical review of test results.

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## Results in Brief

Costs associated with federal agency employee drug testing are both a function of the expense incurred in meeting HHS' scientific and technical guidelines as well as the extent of actual testing. We believe the potential exists for cost savings without compromising program integrity if some guidelines and other aspects are modified. In particular, we identified the potential for cost savings if (1) HHS eliminates the requirement of submitting negative test results to a medical review officer (MRO), (2) HHS reduces its requirements pertaining to aspects of drug-testing laboratory quality assurance programs, (3) agencies reduce the frequency of random drug testing, and (4) agencies consider collecting employee specimens with in-house personnel rather than contracting for this service.

To illustrate, agencies currently vary in the frequency of random drug testing, which ranges from 4 to 100 percent of employees subject to testing per year. However, according to HHS's most recent surveys, covering the period of October 1990 through September 1991, the percentage of positive test results identified through random drug testing does not vary significantly among agencies, regardless of whether the agencies test at a lower level, such as 10 percent, or a higher level, such as 50 percent. On average, the positive test results represent about 0.3 percent of those tested. This percentage may indicate that testing frequencies, whether lower or higher, do not have a direct impact on the deterrent value of drug testing. If the higher levels were reduced, savings would be realized. For example, on the basis of information provided by 4 agencies that randomly tested a total of 28,366 employees for the 12-month period ending September 1991 at a rate of 48 percent or higher, we estimate that drug-testing savings of over \$1 million could be realized if the agencies reduced their testing frequency to 20 percent.

ONDCP and HHS play key roles in providing oversight and guidance to federal agency drug-testing programs. We believe that ONDCP and HHS should take the lead and work with drug testing agencies to consider taking measures where appropriate in order to increase cost efficiencies without adversely affecting program integrity.

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## Objective, Scope, and Methodology

Our objective was to study the costs associated with federal employee drug testing and identify the potential, if any, for cost savings.

We determined the direct costs of employee drug testing from the two most recent Federal Drug-Free Workplace Program Semi-Annual Surveys, which were compiled by HHS and reviewed by ONDCP and the Office of Management and Budget (OMB). The earlier survey covered the period October 1990 through March 1991 and profiled 119 executive branch agency drug-testing programs, including the 51 agencies that conducted drug testing during this period. The survey contained cost information for 48 of the 51 testing agencies. The later survey covered the period of April 1991 through September 1991. It profiled 131 executive agency programs and contained cost information for all 59 agencies that did testing during the period. We did not verify the data submitted by the agencies for the survey or the compilation of these data by HHS.

We analyzed each category of direct costs. In doing these analyses, we reviewed Executive Order 12564 and the HHS guidelines to determine the

extent to which direct costs were driven by existing requirements or other authorities. We interviewed drug-testing officials at the departments of Agriculture, Army, Navy, Housing and Urban Development (HUD), Interior (DOI), Energy, and Transportation (DOT), and at the Bureau of Prisons, the Federal Bureau of Investigation (FBI), Customs and Immigration and Naturalization Services, the Federal Reserve Board, the Consumer Product Safety and Securities and Exchange Commissions, the Public Health Service (PHS), and the Defense Contract Audit Agency. We also compared selected executive branch agency drug-testing program requirements with other programs, such as DOT's program for private sector transportation industry employees and the New York State program.

We interviewed other drug-testing officials, including officials involved in the oversight of employee drug testing at ONDCP and HHS as well as officials from the President's Drug Advisory Council, the New York State Department of Health, the College of American Pathologists, and a private sector health services firm that performs medical reviews for several federal agencies, to obtain their views toward possible cost-savings measures. We also interviewed an OMB official who was involved in putting agency cost estimates together for HHS's semiannual surveys. We reviewed earlier GAO and other reports, and congressional testimony.

We discussed the results of our work with officials from ONDCP and HHS. Their comments are summarized on pages 14 to 16. We did our work between March 1991 and September 1992 and in accordance with generally accepted government auditing standards.

## Medical Review of Negative Tests Is Unnecessary

HHS guidelines require agencies to submit all test results—both positive and negative—to an MRO even though the major objective of the MRO is to review and interpret the positive results. During the period October 1990 through September 1991, federal agencies reported spending nearly 1 million dollars to review almost 117,000 employee drug test results. Because the positive results accounted for about 0.5 percent, we believe savings could occur if only the positive results were referred and not the negatives.

According to one of the primary authors of the HHS guidelines, the requirement to send all test results to the MRO was instituted to protect employee privacy. The author acknowledged, however, that under current operations employee privacy is protected by other means and that it is no longer necessary to send negative results to MROs.

The original privacy concerns focused on the manner in which employee test results were returned from the testing laboratory. A group of test results would be batched at the laboratory and listed as a group on a single sheet and sent to the MRO. The MRO, who is a physician knowledgeable in the medical use of prescription drugs and the pharmacology and toxicology of illicit drugs, would review the positive test results to determine whether the legitimate medical use of drugs or other factors could explain the positive results. If so, the MRO would classify such positive test results as negatives. The MRO would then return all test results to the agency.

A concern existed, according to the HHS guideline author mentioned above, that if the negative test results were immediately sent back to the agency from the laboratory, with the positives sent to the MRO, someone back at the agency could—by process of elimination—identify the names of those employees not sent back by the laboratory as negatives and assume that they were positive for illicit drug use. Such a premature assumption could compromise the privacy of the employees whose positive results were sent to the MRO because the MRO might determine that there was a legitimate medical reason or some other explanation for the positive test result.

The process of returning test results has since been changed. Rather than listing the test results (positive or negative) of a group of individuals together as a composite, the paperwork associated with each individual test specimen is separately sent to the MRO by the laboratory. Thus, if negative test results on any individual are returned to the agency by the laboratory, while any positive test results go to the MRO and later to the agency, it would be more difficult—through the process of elimination—for someone to identify potential positives and make the premature assumption of illicit drug use. This new procedure, according to the HHS guideline author we talked to, makes it more unlikely that a person's privacy would be compromised.

In addition to this change, which makes it more difficult for agency personnel to compromise employee privacy, we do not see the privacy issue as one dictating the unnecessary step and expense of referring the negatives to an MRO. Although we share concerns on employee privacy, agencies should be able to protect employee privacy rights regardless of how test results are returned.

For example, each agency has a drug-testing coordinator to operate the employee drug-testing program. This person, along with any supporting

staff, is responsible for operating the program, including identifying people subject to testing, receiving test results, and coordinating rehabilitation and other actions for individuals testing positive. By virtue of their positions and responsibilities involved, these individuals should be well versed in privacy issues and have the confidence of the agency heads that they would not violate the confidentiality associated with the drug-testing program. In other words, only individuals with the highest integrity should be placed in such positions. Thus, we believe that it is unnecessary to take the current steps to protect employee privacy when ultimately only individuals who have proven to be trustworthy should have access to the results.

Precise estimates of the cost savings from not sending negative test results to MROs are not possible because, as we noted in a 1991 GAO report,<sup>1</sup> the amounts and methods by which MROs charge for their services vary greatly. As a result of this variance, it is not always possible to break out a separate cost for review of negative test results. For example, some MROs charge from \$50 to \$200 per hour, while others reported charges ranging from \$8,400 to \$30,000 on an annual basis. We were not able to determine what portion of such costs should be allocated to the review of negative test results. An MRO that provided services in 1991 to three agencies reported separate charges, depending on whether the test under review was positive or negative. She reported charging \$1.70 per negative test. If we use this charge and multiply it by the approximately 117,000 negative tests sent for review during the 12-month period ending September 30, 1991, potential savings could be over \$198,000.

The possibility for revising the HHS guidelines to eliminate the requirement and cost of sending negative tests to MROs is shared by others. For example, we discussed this issue with (1) an MRO for the FBI, (2) the owner of a firm reviewing samples for DOI and its contracting agencies, and (3) administrators of medical reviews at PHS. In total, these organizations processed more than 32,000 drug test samples in fiscal year 1991. Each organization said the review of negative tests is unnecessary. For example, a PHS official said that a PHS review of negative test results is limited to ensuring that the laboratory copy of the chain of custody form has all the needed signatures and other information.<sup>2</sup> PHS administrators also said that

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<sup>1</sup>Employee Drug Testing: A Single Agency Is Needed to Manage Federal Employee Drug Testing (GAO/GGD-91-25, Jan. 18, 1991).

<sup>2</sup>The chain of custody form begins with the sample collector who dates and signs the form. The form is dated and signed by anyone who accepts and releases the specimen. Anyone handling the specimen must also note the purpose of its transfer.



the collector's copy of the chain of custody form is checked to make sure it matches the laboratory copy.

Such checks of the chain of custody forms are important for positive test results because any errors would make the test invalid. These checks are less important for negative test results because the employees who would receive them would not challenge the results. In addition, according to the MRO at the FBI, such checks are purely administrative in nature and could easily be done by agency personnel.

A professional conference has also addressed the requirement for having MROs review negative test results. A 1989 Consensus Conference sponsored by HHS's National Institute on Drug Abuse brought together government officials, scientists, physicians, and representatives of business, industry, and labor to discuss key issues of employee drug testing. The conference's working group on medical review issues recognized that the review of negative drug test results incurred questionable costs, but no consensus was reached on the issue.

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## Extent of Blind Proficiency Testing Might Be Reduced

The HHS guidelines impose quality assurance controls over laboratories that analyze drug test urine specimens. One of these controls is blind proficiency testing, which requires the agencies to buy and send urine samples to the laboratory. With these tests, the laboratory is unaware that these are test samples, and the agency monitors the accuracy of the laboratory in analyzing these test specimens. While blind proficiency testing is an important element of quality assurance programs, our work showed that HHS's blind proficiency testing requirements exceeded those of other drug-testing programs and possibly could be reduced at a cost savings without compromising quality assurance.

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## Current HHS Quality Control Requirements

HHS guidelines contain multiple quality assurance controls for drug-testing laboratories. Summaries of the key controls follow.

- Laboratory internal quality control programs. Laboratory internal quality assurance procedures are to be designed, implemented, and reviewed to monitor the conduct of each step of the process of testing for drugs. This process requires that each analytical run of specimens to be tested include urine specimens certified to contain no drugs or known amounts of drugs. A minimum of 10 percent of all test samples screened shall be quality control specimens.

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- **Open proficiency testing.** HHS or a recognized certification program sends urine specimens that are known to have quantities of drugs in them, or are known to be drug-free, to the laboratory for analysis 4 times per year on a quarterly basis. These are open performance tests in that the laboratory knows it is being evaluated.
  - **Blind proficiency testing.** According to HHS guidelines, each agency that contracts with a laboratory must send blind test samples for analysis. These are blind performance tests in that the laboratory does not know that it is being evaluated. After the first quarter of testing, the agencies must provide blind test samples equal to a minimum of 10 percent of its employee samples processed per quarter (up to 250 samples per quarter). During the first quarter of testing, agencies must provide test samples equal to at least 50 percent of the samples submitted (up to 500 samples per quarter).

In addition to the above quality assurance requirements, the HHS guidelines require a laboratory to receive HHS certification before it can be used by a federal agency to analyze employee drug-testing specimens. The certification process includes a determination by HHS of the adequacy of the laboratory facilities, the expertise and experience of the laboratory personnel, the adequacy of the laboratory's quality assurance and quality control program, the performance of the laboratory on any tests related to the certification process, and the laboratory's compliance with standards as reflected in laboratory inspections.

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### Comparison With Other Organizations' Proficiency Testing Requirements

We compared the HHS blind proficiency testing requirement with other programs and found that it may be unnecessarily extensive. For example, in 1989 DOT established regulations mandating drug testing for about 4 million private sector transportation workers. DOT's requirement for blind proficiency tests for its private sector drug-testing programs calls for test samples equal to 3 blind samples per 100 employee specimens, up to 100 blind samples per quarter. According to a DOT official, this lower rate was determined adequate, given the fact that the laboratories had to meet HHS's other quality assurance measures, such as the laboratory certification process.

Moreover, two nonfederal programs do not require such testing at all. According to an official with New York State's Department of Health, which certifies laboratories to perform state employee drug tests, the state program requires laboratories with New York State permits to follow HHS guideline requirements for internal quality assurance but does not use

blind testing. In the official's opinion, the decision to use such tests should be based on the laboratory's performance over time. Similarly, an official from the College of American Pathologists said that his organization uses open, rather than blind, testing as a means of ensuring the quality of its member laboratories.

Although exact comparisons are difficult, the cost savings realized by a reduction in the government's requirements for blind testing samples can be estimated. For our estimate, we used the blind testing purchase price (\$34.23) and laboratory analysis cost (\$9.41) from DOI's contract because about 68 federal agencies have also entered into this contract to purchase their blind samples and analytical services. In addition, from the Federal Drug-Free Workplace Program Semi-Annual Surveys covering the period October 1990 through September 1991, we used the 116,732 drug tests federal agencies reported conducting. Assuming that the agencies submitted blind samples equal to approximately 10 percent of these tests (11,600), we estimated a total purchase and testing cost of more than \$500,000 for the year.<sup>3</sup> However, had they submitted blind samples equal to only 3 percent of those tests, they would have spent about \$150,000 for these services, saving about \$350,000.

Industry and government officials have questioned the 10-percent rate mandated by HHS for blind proficiency testing. For instance, one of the authors of the guidelines told us that he believes the current requirement is excessive. He explained that when the guidelines were written, drug testing was in its infancy and that the authors accordingly erred on the side of quality assurance rather than cost efficiency when they established the 10-percent rate. The issue of the 10-percent rate also surfaced at the 1989 Consensus Conference, at which HHS and other members of the drug-testing community discussed the possibility of reducing the requirement. Though no consensus was reached on what rate would be sufficient to provide quality assurance, some participants suggested that 3 percent, up to 100 samples per quarter, would be appropriate.

Although we do not know whether a 3-percent or some other level would be appropriate, it appears reasonable for HHS and ONDCP to reevaluate the current required level for blind proficiency testing. This evaluation should consider, among other things, the experience and practices followed by other employee drug-testing programs as well as other complementary

<sup>3</sup>Because the HHS guidelines place a limit of 250 blind proficiency tests required per agency per quarter, the actual number of tests required might have been less than 11,600. The HHS surveys did not include sufficient information to make this determination.

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elements of the quality assurance program, such as open proficiency testing and the laboratory certification process.

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## Drug Testing Frequency Might Be Reduced With Resulting Cost Savings

Under Executive Order 12564, each executive branch agency was given the discretion to determine its own random testing frequency—the percentage of the employees in sensitive positions subject to drug testing that are tested annually. As we discussed earlier, the frequency of drug testing in agencies varies widely and has ranged from 4 to 100 percent of employees per year. Because the frequency of drug testing affects the number of tests done and contributes to drug-testing costs, savings could be realized if agencies reconsidered and reduced the frequency of drug testing.

It appears that the different testing frequencies are based largely on the judgments of agency management in designing their programs. For example, a 1991 GAO report provided the status of federal agencies drug-testing programs.<sup>4</sup> We included a profile of the programs of nine agencies, seven of which provided an explanation of why a particular frequency was chosen. The summaries of these explanations follow.

- One agency picked a 4-percent frequency because the agency believed it would give a 95-percent sampling confidence level.
- Two agencies chose a 50-percent frequency because they wanted to ensure employees were not drug impaired and/or to provide a deterrent to drug abuse.
- One agency picked a 5-percent frequency and said that there was no particular rationale for it but that cost was a factor.
- An agency that picked a 15-percent frequency said it thought this level was in line with other agencies.
- One agency said its 10-percent frequency was judged to be an adequate deterrent and that cost was also a factor.
- One agency said that a frequency of 25 percent was thought to be reasonable.

Although we have no basis for saying there is anything wrong in any of these decisions, we do note they are largely judgmental. Given the subjectivity of these judgments, it is reasonable for agencies to reconsider the levels initially chosen.

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<sup>4</sup>Employee Drug Testing: Status of Federal Agencies' Programs (GAO/GGD-91-70, May 6, 1991).

The potential for cost savings if the drug-testing frequency levels were reconsidered and reduced is simply a function of the number of drug tests that are reduced multiplied by the cost of each drug test. Precise estimates of savings are not possible because no single-cost figure per test exists throughout the executive branch and, of course, no one knows what, if any, reduction in drug-testing frequency might occur. However, we have illustrated potential savings in table 1.2, using information provided by four drug testing agencies—the Nuclear Regulatory Commission (NRC), HUD, DOT, and the Department of the Army—for the HHS surveys covering the 1-year period ending September 1991. For the purpose of the table, we identified the costs incurred in testing at the agencies' actual frequencies and estimated what the savings would be if the frequencies were reduced to 20 percent.

**Table 1.2: Potential Savings If the Frequency of Testing Is Reduced to 20 percent**

<b>Agency</b>	<b>Actual frequency (in percent)</b>	<b>Number of random tests</b>	<b>Costs</b>	<b>Estimated savings if reduced to 20 percent</b>
NRC	61	951	\$ 105,561	\$ 70,929
DOT	54	19,083	1,641,138	1,036,558
HUD <sup>a</sup>	48	236	18,880	10,960
Army	111	8,096	72,864	59,760
<b>Total</b>		<b>28,366</b>	<b>\$1,838,443</b>	<b>\$1,178,207</b>

<sup>a</sup>HUD testing was for the 6-month period covering April through September 1991.

As the table shows, the four agencies could save over \$1.1 million over the 12-month reporting period by reducing their current drug-testing frequency to 20 percent. More or less savings would occur if a lower or higher frequency was selected. Interestingly, other data provided by the agencies in the HHS surveys on the number of positive test results found in random testing showed the number of positives does not appear to be significantly influenced by the frequency of testing. For example, the percentage of positive test results for the four agencies ranged from 0 to 0.21 percent. During the same period, the Air Force, which tested at a lower rate of 21-percent frequency, reported 42 positives out of 5,381 tests, or 0.78 percent.

We recognize that potential cost savings is not the sole factor that needs to be considered when deciding the frequency of drug testing. Among other things, the need to ensure the health and safety of the public, the value of

providing a deterrent to illicit drug use, and the value of identifying and referring drug users for treatment also need to be considered. However, given the low rate of positive test results—0.3 percent for random testing—and the general subjectivity involved in the initial agency determinations of the frequency rates that agencies would test at, we believe it would be reasonable to revisit the issue of drug-testing frequency.

As part of its oversight function for federal drug-testing programs, ONDCP could play a coordinating and leadership role in reconsidering frequency rates. ONDCP might have agencies consider such factors as the history of drug abuse within the agency as well as alternatives to random testing. For example, agencies are authorized to test employees when an accident occurs or when there is reasonable suspicion of drug abuse.

## Cost Savings Have Been Achieved Through In-House Collections

Under HHS guidelines, each agency is responsible for obtaining urine-sample collection services, and most, according to an agency official, contract for these services. However, four federal agencies are performing their own collections, and two are demonstrating savings.

Both the Bureau of Prisons and the Department of the Army use their own personnel to collect samples. Because an official from each of these drug-testing programs could not provide us with cost comparisons between their in-house collections and possible costs if they contracted out, these agencies could not provide us with any estimate of savings. However, the FBI and DOI, who also collect their own specimens, were able to do so.

According to its program administrator, the FBI has done its own sample collection since the beginning of its drug-testing program in 1986. FBI data indicated that it saved more than \$104,000 in fiscal year 1991 by using in-house personnel to collect all employee samples nationwide (6,242 specimens).<sup>5</sup> DOI's program manager told us that his agency does many of its own collections for employees in the District of Columbia and in some of its field locations. As part of their official duties, some DOI employees are trained to handle collections. Information from DOI indicates that between March 1991 and March 1992, it saved more than \$20,000 for 1,042 in-house collections.

<sup>5</sup>According to the administrator, collections are handled by personnel employees of GS grades 5 to 7 and take approximately 15 to 20 minutes each.

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We did not verify the cost savings estimates provided by the FBI and DOI or examine whether in-house collections might cause other operational difficulties, such as taking employees away from their other duties. Further, we recognize that in-house collections may not be feasible for all agencies or circumstances. For example, an official at the Department of Agriculture and an official at HUD cited several reasons against it—difficulty in securing space for collections that would meet the HHS guidelines, employee privacy, the cost of in-house collectors, security demands, etc. However, considering the feasibility of in-house collections at federal agencies is reasonable.

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## Conclusions

We looked at potential ways to increase cost-effectiveness and found several opportunities. Some agencies have opted to collect drug-testing specimens using agency personnel rather than contracting out and have reported cost savings. The efforts of these agencies might be considered by others.

Other cost-savings opportunities would require modifications to HHS guidelines concerning (1) the current level of blind proficiency samples as part of the quality control programs of agencies and (2) the submission of negative test results to MROS. Although both requirements may have been appropriate in 1988, when the guidelines were published, circumstances have changed, and it is reasonable to revisit the requirements and consider modifications.

The frequency of drug testing—the percentage of those individuals subject to drug testing that are actually tested per year—can also be looked at. We have found that agencies' testing frequencies vary widely, ranging from 4 to 100 percent of the employee population subject to testing. These frequencies were developed subjectively, however, with some agencies viewing a 10-percent level sufficient to deter drug use with others viewing a 50-percent or higher level necessary. Given such subjectivity, it is reasonable for agencies to review their selected testing frequencies with a view toward reducing them where appropriate.

In their oversight roles over federal agency drug-testing programs, we believe ONDCP and HHS should take the lead as appropriate in reviewing these and other possible cost-savings measures.

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## Recommendations

To increase the cost-effectiveness of federal employee drug testing, we recommend that the Director of ONDCP and the Secretary of HHS together consider the feasibility of (1) eliminating from existing guidance the requirement that negative test results be submitted for medical review and (2) reducing the required rate of blind proficiency testing. Further, we recommend that the Director of ONDCP and the Secretary of HHS work with drug-testing agencies to consider the feasibility of collecting drug-testing samples with agency personnel rather than contracting out for this service. We recommend that the Director of ONDCP also work with drug-testing agencies to consider modifications to their selected frequency levels of employee drug testing.

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## Agency Comments

We discussed the results of our work with officials from ONDCP and HHS. Their comments on the four possible cost-savings areas discussed in our report and our observations follow.

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## MRO Review of Negative Test Results

Regarding our recommendation that ONDCP and HHS consider eliminating the requirement of submitting negative test results for medical review, the HHS official expressed continued concern regarding privacy issues. The official believed that an agency employee could, through the process of elimination, identify potential positives because they were not returned with the negatives. The official also said that the MRO evaluates documentation from the laboratory on the negative test results, such as whether the urine specimen was rejected by the laboratory because of tampering or specimen adulteration or chain of custody problems. The official said that only by reviewing all test results, not just the positives, could the MRO effectively judge program effectiveness. The ONDCP official did not address this issue.

As we say on page 4, we believe that it should not be necessary to send all test results (negative as well as positive) to an MRO in order to safeguard the privacy and confidentiality of employee drug testing. Agency employees involved in the drug-testing program should have the necessary training and integrity to safeguard this sensitive information.

Further, it appears that not all MROs are evaluating all of the documentation on the negative test results from the laboratory as suggested by the HHS official. The MROs with whom we discussed this issue during our work told us that other than reviewing the chain of custody forms for such items as proper signature, no review of the negative test



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results was required or done. Also, neither the HHS guidelines nor the HHS MRO manual contain specific responsibilities regarding how the MRO is to treat negative test results. Thus, there is no written requirement that MROs do the type of evaluation cited by the HHS official. However, if such evaluations would be useful, they could be done by agency drug testing program staff. In addition, in our view such examinations of the documentation from the laboratory would be largely administrative in nature and would not require any specialized or scientific expertise.

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### Potential to Reduce the Rate of Blind Proficiency Testing

The ONDCP official said our discussion of the proficiency testing program might imply that we do not support the need for blind testing to ensure program quality. We did not intend such an implication, and we have modified language in the report to clarify that we are only raising the issue of whether blind proficiency testing needs to remain at its present level. The HHS official said that his agency is looking at the possibility of revising its guidelines by lowering the number of blind proficiency tests required. He said a final decision has not yet been made on the issue.

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### Frequency of Drug Testing

The ONDCP official said that perhaps ONDCP could write a memorandum to agencies requesting that they review their drug-testing frequencies. He said that in January 1992 ONDCP issued a similar memorandum requesting agencies to review the positions that had been selected for drug testing. According to the official, that memorandum was successful in getting many agencies to eliminate unjustified testing designated positions. However, he said that a memorandum from ONDCP asking agencies to review their testing frequencies might be used as justification by some agencies that do not support drug testing to eliminate the drug-testing part of the drug-free workplace program altogether. He said he was convinced that some level of testing was necessary to ensure a deterrent to illicit drug use. The HHS official did not raise a concern with this issue.

Our recommendation that ONDCP work with agencies to consider reducing testing frequencies is not aimed at eliminating the random testing portion of the drug-free workplace program. Rather, given the history of agency drug-testing programs and the low rate of positive test results, we are suggesting that the higher levels may not be needed. These levels might be reduced at a cost savings without harming program integrity.

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### In-House Drug Testing Specimen Collections

The HHS official said he was only concerned with using an agency employee to collect the urine specimen of another agency employee under

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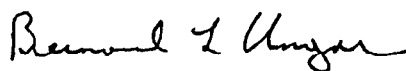
certain circumstances, such as for post-accident testing or for employees suspected of using illegal drugs. The official said that in such nonrandom testing situations, the employee to be tested is being singled out from the rest of the population and that the collector would be aware of it and could breach the privacy of the employee. The ONDCP official said that OMB Circular A-76, which directs agencies to contract out for services when it is cost-effective to do so, may affect the in-house collection issue.

In our view, these issues are not insurmountable. The collectors could be members of the drug-testing program staff and by virtue of their positions would be aware of the need to protect employee privacy and program confidentiality. Another alternative might be that in those situations where an employee is tested for nonrandom purposes, the agency could use a private collection firm. In-house collectors could be used for the bulk of the collections when it is cost-effective. We believe agencies should adhere to Circular A-76 in deciding whether to use contract or in-house collectors. Our recommendation is aimed at ONDCP and HHS working with the agencies to consider the possibility and cost-effectiveness of using in-house rather than contract facilities for specimen collection. Adherence to Circular A-76 requirements would be an important factor in this consideration.

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As arranged with the Subcommittee, unless you release the contents of this report earlier, we plan no further distribution until 30 days after the date of this report. At that time we will send copies to the Directors of ONDCP and OMB, the Secretary of HHS, and other interested parties.

The major contributors to this report are listed in the appendix. If you should have any questions on this report, please contact me at (202) 275-5074.



Bernard L. Ungar  
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