USPSTF Did Not "Connect the Dots" Between Early Detection and Intervention

Our plea is for the US Preventive Services Task Force (USPSTF) to "connect the dots" between early detection and early intervention (EI) before bluntly concluding that there is insufficient evidence to assess the benefits and harms of screening children for language delays.[1] We believe primary care providers (PCPs) should adhere to the American Academy of Pediatrics' (AAP's) recommendations for developmental-behavioral surveillance and screening, and agree with Voigt and Accardo's[2] pleas for PCPs to receive enhanced training in developmental-behavioral pediatrics.

Periodic screening enhances surveillance and early detection.[3,4] When a psychometrically sound screen is problematic, this should lead to EI and its many well-established benefits. The term "language delay" embraces a raft of problems from the typical delays of dual-language learners, to language deficits due to psychosocial stressors (eg, exposure to poverty, maternal depression, domestic violence), to an array of neurodevelopmental disorders/disabilities as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (eg, communication disorders, intellectual disabilities, autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disability, and even motor disorders). Neurodevelopmental disorders may not be curable, but EI teaches invaluable compensatory strategies, reduces comorbid mental health problems, enables children with lifelong disabilities to become more productive citizens, and improves quality of life for children and their families.[4,5]

Unfortunately, the important distinctions among the etiologies of language delays, and the wide assortment of evidence-based interventions for children 0 through 5 years[5] was not adequately captured by the USPSTF's systematic review or Voight and Accardo's[2] commentary.

What is befuddling is that the AAP is not even recommending universal language-specific screening. Rather, the AAP recommends universal, broadband developmental-behavioral screening at 9, 18, and 24 to 30 months, plus autism screening at 18 and 24 months, plus an appropriate screening whenever surveillance indicates "risk." Language-specific screens are more commonly used by speech-language pathologists or other professionals who have the time and clinical acumen to sort out psychosocial-mediated language delays from neurodevelopmental disorders, and other competing conditions like hearing loss.

The AAP's recommendations acknowledge that language deficits are a presenting feature of many different conditions, a topic inadequately addressed by the USPSTF. Thus, the advisability of focusing solely on screening for language delay is elusive. Psychometrically sound, broadband screens are designed to detect a wide range of developmental-behavioral problems at 15- to 30-minute well-visits. Previsit screening with broadband tools heightens professional scrutiny and upholds the Institute of Medicine's 6 improvement aims: care that is effective, safe, patient/parent-centered, timely, efficient, and equitable.[3]

Voight and Accardo's disparaging comments[2] about the value of parent-report, broadband screens is thoroughly unfounded. Psychometrically sound instruments, such as the Ages and Stages Questionnaires and Parents' Evaluation of Developmental Status Tools, have acceptable rates of sensitivity and specificity.[3,4] When implemented safely, screens do not prematurely label children with a diagnosis. They can enhance parent-provider communication and promote developmental-behavioral wellness.[3,4] Studies show clinical judgment alone is a woefully inadequate (not timely) method of early detection; only 30% to 40% of children with problems will be detected.[3,4] "As-needed" screening after the well-visit is disruptive to clinic flow (not efficient) and unfortunately, relies on clinical judgment. Universal administration ensures an equitable approach in which all receive well-researched questions and cutoff scores.

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Conflict of Interest:
Dr Glascoe is the author of and receives royalties for the Parents' Evaluation of Developmental Status (PEDS), Parents' Evaluation of Developmental Status: Developmental Milestones (PEDS:DM), and Brigance Screens. Dr Marks has no conflicts of interest relevant to this article to disclose.

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Follow-up After Screening

The USPSTF concluded: "We found no evidence to answer the overarching question of whether screening for speech and language delay or disorders improves speech and language outcomes."

Although we advocate for developmental screening, we recognize the many uncertainties about speech-language screening found by the USPSTF. Much research remains to be done. Future reviews should recognize that the yield of screening depends in large part on the prevalence of delay in the sample under study.

Another aspect addressed less frequently is the importance of follow-up after screening and referral. In the 3 most recent studies, the proportion of children referred for evaluation who were evaluated and who qualified for services (the predictive value of a referral) was 33% (86/261),[1] 23% (26/115),[2] and 56% (64/81).[3] To improve these figures will require work across our systems and in all our communities.

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None declared.

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Author's Response

We appreciate the comments from Dr Marks and Dr Glascoe. As primary care physicians and members of the US Preventive Services Task Force (USPSTF), we share their dedication to improving the health of all children, including those with possible language and other developmental problems. We would like to emphasize that the USPSTF is not arguing against screening for speech delays or disorders. Instead, the USPSTF identified a critical gap in the evidence needed to demonstrate that routinely screening all children for language delays and disorders in primary care might improve language outcomes. Dr Marks and Dr Glascoe point to the potential benefits of broadband screening instruments for identifying a wide array of neurodevelopmental problems in children. Although such screening might be of value, its use goes beyond the specific aims of this USPSTF evaluation, which focused specifically on language. The USPSTF has not evaluated the use of broadband screening instruments or surveillance over time to identify neurodevelopmental problems, and therefore cannot make a recommendation about these approaches.

The USPSTF applies a high standard when interpreting available evidence and translating the evidence into recommendations. It considers not only the validity of screening tests but also the evidence regarding the outcomes in cases detected through screening compared with the outcomes that would occur in the absence of screening. The question is not just about the psychometric characteristics of specific screening tests but whether their routine use in primary care improves outcomes in children. The USPSTF issues an "I statement" when the evidence is not adequate to allow this comprehensive assessment. I statements are not recommendations against screening but calls for more research and better evidence. We believe that such statements are the best representations of current evidence and will ultimately lead to the information needed to provide the best care for children and their families.

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