

POLICY STATEMENT

Universal Newborn Hearing Screening

There are psychosocial, linguistic, and educational advantages for children who receive appropriate management for their hearing condition at an early age (Ross, 1998). Studies completed over ten years ago have shown that the English language and auditory skill development is superior for these children compared to those whose hearing loss is detected and managed at a later date (Watkins, 1987; White & White, 1987; Levitt, McGarr, & Geffner, 1987).

In the most recent study of this type (Yoshinaga-Itano, Sedey, Coulter, & Mehl, 1998), the earlier results have been corroborated. It was found that children whose hearing losses were identified before six months of age demonstrated significantly better language scores than children whose losses were detected later. Early management can also spare parents the years of agonizing uncertainty and feelings of helplessness that often occur when there is a delay in the detection of their child's hearing loss. In short, there are compelling reasons for the necessity to detect hearing loss in children at an early age, with no apparent dissenting voices.

Until recent years, however, there has not been an efficient and cost-effective way of identifying hearing loss in newborn infants on a universal scale. Previous efforts often resulted in too many normally hearing children "failing," or too many children with hearing loss "passing." In the last several years, technical developments have made it possible to efficiently set up a nationwide newborn infant hearing screening program that is both accurate and relatively inexpensive. Existing models in several states clearly demonstrate that infant hearing screening programs using the otoacoustic emission (OAE) phenomenon can reliably and accurately identify the presence of a hearing loss.

These programs are administered by audiologists, and conducted by medical technicians and nurses under the supervision of an audiologist. Children who fail the hearing screening at least twice are referred to an audiologist for an auditory brainstem response (ABR) test. The results of this test can accurately estimate the degree and general configuration of a child's hearing loss in each ear. Once these measurements are made, and after an otolaryngological examination is conducted to consider the medical implications of the hearing loss, it is then necessary to provide for a comprehensive management program for the infant and his/her family by qualified early intervention specialists, state health agencies, the state educational system, and consumer and parent organizations. Such a program would include the selection and fitting of an appropriate amplification device or determining whether or not a child is a cochlear implant candidate. Indeed, and this should be stressed, without such a management program the process would be incomplete.

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Thus, a model universal newborn hearing screening program would include the following components: hearing screening, diagnostic audiological testing, a medical examination, and a habilitation process that is a component of, and flows from, the identification and diagnostic procedures.

The Hearing Loss Association of America supports the state and local efforts, including legislation, that ensure newborn hearing screening is considered an essential part of routine newborn screening procedures. Furthermore, we recommend that such legislation directly or indirectly address the necessity for a linked non-medical habilitation component.

Hearing Loss Magazine, March-April, 1999

References:

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