Chapter 20

De/Re-institutionalising deafness through the mainstreaming of deaf education in the Republic of Ireland.

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Introduction

In the last number of decades, education policy has begun to focus on the inclusion of children with special educational needs in their local public school. This population is predominantly composed of those with physical, sensory, intellectual, emotional and behavioural differences. Their inclusion in mainstream schools is driven by ideals of deinstitutionalisation, viewing the amalgamation of children with disabilities with their nondisabled peers as a means of promoting social and educational equality, and is influenced by the civil rights movements from the 1960s and the rise of the social model of disability. However, the process of deinstitutionalisation is frequently limited to the spatial realm, moving children from previously segregated environments to so-called integrated environments, providing adaptations to the physical school building with less emphasis on staff training or attitudinal changes (Kitchin and Mulcahy 1999b). Subsequently, mainstreaming continues to be heavily influenced by pathological views of disability driven by the medical model and its variations which continues to focus on curing disability and normalising difference (Holt 2003).

This is particularly evident in the case of deaf education, where mainstreaming of deaf[1] students frequently relies on the ability of that student to communicate through speech, listening and lip-reading as opposed to the use of sign language in the general classroom (Hyde and Power 2004). Alternatively, adequate access to the curriculum through the means of sign language, as well as instruction for hearing students and staff in sign language can facilitate mainstreaming of deaf students, a situation which occurs frequently in the US. However, in the Irish context, owing to a lack of provision of Sign Language interpreters in the mainstream environment the former situation is much more common. Subsequently, the mainstreaming of deaf students instead of addressing the stigmatisation of deafness by promoting awareness of sign language and Deaf Culture, adds to the pathological view of hearing impairment by placing an emphasis on the need to adapt the deaf child to the hearing classroom, often through medical interventions aimed at ameliorating their impairment. Indeed, it could be claimed that mainstreaming, instead of *de*institutionalising deaf students, is merely *re*institutionalising them; rearranging their spatial organisation away from the brick and mortar institutes of segregated residential schooling into a spatially dispersed institution of local schools, an institution which although it lacks the spatial delimitations of traditional institutions nonetheless remains overtly driven by institutional ideologies and a medical model of deafness. This medicalisation is supported by interventions taking place in the family home, which in the case of deaf

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[1] There has been much debate in the last number of years regarding the varying use of the terms deaf (lowercase), Deaf (uppercase), hearing-impaired, hard of hearing, and so forth (see Skelton and Valentine, 2003 for discussion). Throughout this paper, the term deaf will be used highlighting the fact that the majority of participants in this research had hearing losses over that which would categorise them as hard of hearing, and do not yet identify as culturally Deaf, nor do they use Irish Sign Language as their dominant mode of communication. Where the term Deaf is used, it is used specifically to indicate cultural Deafness, identification with the Deaf Community, and use of Sign Language.

children becomes part of the institutional network negotiating the 'treatment' of deafness. Therefore, as Holt (2003) observes ‘the [Special Educational Needs] process can be understood as an institution, which operates within and between schools’.

This chapter will examine this process of de/re-institutionalisation in the Republic of Ireland focusing on the example of deaf education and consists of two broad sections: section one traces the development of mainstreaming deaf education and highlights the difficulties when deinstitutionalisation is approached as a primarily spatial practice. Section two uses empirical findings to examine how mainstreaming is subsequently a process of *re*institutionalisation for deaf children, where normalisation and medicalisation remaining highly influential forces. These empirical findings come from a doctoral research project on mainstreaming of deaf education in the Republic of Ireland. The findings presented here are from semi-structured open-ended interviews conducted with either one (usually mothers) or both hearing parents from 20 families with deaf children. At the time of the first interviews these children were aged between 18 months and 16 years with an average age of 8 years. While there has been much work recommending the inclusion of children’s voices, especially marginalized children, instead of consulting parents or teachers on their behalf (Porter and Abane 2008, Rose and Shevlin 2004, Schafer and Yarwood 2008), the consultation of adults remains a justifiable approach to understanding children's geographies. In the context of this research, since the decisions regarding educational placement are largely made by parents when deaf children are still infants or young children, parents are the best sources of information regarding this early phase of their child's life. Parents were recruited through schools, contacts with the Deaf Community, and a series of five information nights held across the country aimed at promoting the research. Interviews with these parents ranged from half an hour to two hours and were conducted in spoken English, recorded using a Dictaphone, with the recordings transcribed and coded for analysis. Three of the families interviewed had migrated to Ireland while the remaining families had at least one parent who was Irish.

As well as the interviews with parents, 24 professionals working with deaf children were also interviewed: seven teachers in self-contained units for deaf children in mainstream schools, five general teachers in mainstream schools, two resource teachers in mainstream schools, two principals in mainstream schools, one special needs assistant, one Irish Sign Language tutor, and six other professionals working in service provision and research in deaf education. The vast majority of these professionals were hearing, with only two identifying as Deaf and another identifying as hard of hearing, although not a member of the Deaf Community. Those identifying as Deaf were interviewed in the Irish Sign Language[2], with the remaining 22 interviewed in spoken English. In line with emancipatory and participatory research methodologies which honour meaningful involvement of communities affected by research (Oliver 1992), the Deaf Community were informed of and guided this research project through a series of five information nights held in urban centres across the country. The information nights were followed by informal group

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[2] Interviews were conducted without the use of an interpreter; the principal investigator is a competent user of Irish sign language. Member checks were conducted to ensure the accuracy of English glosses provided to the sign language interviews.

discussions, and there was one formal focus group meeting with members of the Deaf Community. Seven young deaf people were also included through paired interviews. Because of the nature of this discussion however, the bulk of the findings reflected upon in this chapter will consist of the interviews with parents and professionals.

(De)Institutionalising Deaf Education *or* The Problem with Mainstreaming

From the 1970s on, there has been an increased move towards integration and more recently inclusion of children with disabilities, so much so that as Holt observes 'there is a growing international hegemony, which identifies the mainstream school as *the* place to educate (most) disabled children' (2003 original emphasis). Mainstreaming policies are supported by legislation on both national and international levels through legislative acts (Government of Ireland 2004) and statements such as the Salamanca Statement (UNESCO 1994). All of these legislative acts promote the mainstream school as the ideal educational environment for children with disabilities[3] , in which they will achieve their 'fullest educational progress and social integration' (UNESCO 1994) by being included in their local mainstream school and provide parents with the legal entitlement to pursue that education for their child. As a result of these policy measures, there has been a noticeable increase in the numbers of children with disabilities being educated in their local mainstream school and a simultaneous decrease in those attending specialized schools. Regarding deaf education, it is estimated that over 90 per cent of deaf children are currently enrolled

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[3] Clauses exist should mainstream placement be detrimental to either the child with disabilities or their peers (see the EPSEN act section 1 paragraph 2 for example) Government of Ireland (2004) Education for Persons with Special Educational Needs Act. Republic of Ireland..

in mainstream programmes, although this represents a wide range of placements (Kluwin 1992), from those in full integration programmes (where they may be the only deaf child in the class) to those enrolled in special classes within mainstream schools (where they may attend classes with mainstream peers for certain subjects as well as being integrated for extracurricular activities). In the Irish context, it is the former which makes up the vast majority of mainstream placements with only a small proportion of deaf children attending one of the eight units for deaf children within mainstream primary[4] schools across the country.

This mainstreaming process has, to an extent, been heralded as the end to the institutionalisation of children with disabilities and has been welcomed by many, who viewed institutionalized 'special' education as inhibiting the full participation of people with disabilities in their local communities (Griffin and Shevlin 2007), ghettoising disability (Smith 2005), and failing to prepare children for competing in the workforce (Kitchin and Mulcahy 1999a). However, there has also been notable reluctance from some regarding the mainstreaming project, a reluctance which has been particularly felt in the field of deaf education. Several studies have indicated that mainstreaming deaf education can indeed be problematic. Antia, Stinson *et al* (2002) highlight several more-than-spatial barriers which prevent the full inclusion of deaf and hard-of-hearing children in mainstream settings across four categories: teacher issues, student issues, administrative and structural issues, and community issues. Minnet*, et al* (1994) observed that preschool children preferred to have friends of the same hearing status in spite of integration while Stinson *et al* (1996) and Musselman

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[4] This research focuses on primary mainstream education only.

et al (1996) noted that older deaf students continued to relate better to their deaf peers, a fact which was not affected by increased mainstreaming and interaction with hearing classmates. This can be aggravated by difficulties with acceptance from hearing peers (Antia and Kreimeyer 1997). Skelton and Valentine (2002) found that while deaf participants reported coping with mainstream primary school, their secondary mainstream experience was fraught with bullying, limited academic opportunities, poor communication, and inappropriate life skills training. In Australia, Hyde and Power (2004) have highlighted that while many deaf students may be competitive academically, their social involvement in mainstream school placements remains problematic. Furthermore, for deaf students who have been mainstreamed, there can be difficulty associating with deaf peers as well as hearing peers during third level education, with feelings of being stuck between both worlds commonly reported (Kersting 1997), indicating that the effects of mainstreamed education last into adulthood. Overall, research suggests that the linguistic needs of deaf students mean that for meaningful inclusion within mainstream classrooms to occur, both physical and attitudinal adaptations are necessary, in particular instruction in sign language as well as deaf awareness training to both children and teachers within the school (Gaustad 1999). Thus, the Salamanca statement which provides guidelines for the mainstreaming movement acknowledges that the example of deaf children may be one where segregated education is more appropriate and beneficial then integrated education (UNESCO 1994).

These findings point to the fact that in mainstreaming practice, simple physical integration is not enough, and by focusing on spatial proximity to peers we fail to acknowledge the complexities underlying the (de)institutionalisation process, in particular the ideological foundations for both segregation and inclusion as they relate to deaf children. The primary concern underlying these criticisms lies in the fact that this approach to deinstitutionalisation through mainstreaming has often focused on the spatial, in spite of policy calls to the contrary (see UNESCO 1994 I:6), where in practice mainstreaming in its many forms confuses physical integration with social inclusion (Smith 2005). As Komesaroff and McLean (2006) highlight ‘although initially driven by concerns of social justice, inclusion can be viewed as the relocation of students for compliance with policy’ and that it has simply become a case of 'add and stir' in managing difference within the school population. However, although highly spatial (de)institutionalisation, is by no means exclusively a spatial process, and to focus on it as such is to deny the highly ideological nature of the process.

The institutions central to our society are not spatially fixed neutral entities, but are highly loaded, contested, multi-spatial cites that are often used as a tool for achieving specific political, social and economic goals (Green et al. 2008). The spatial segregation, confinement, and treatment of classified 'others', including deaf children, over the last two centuries required an ideological basis, to be found in the scientific and medical rationalisation of the supposed ‘superiority’ of certain populations over others and the need for normalising treatment among those deemed 'inferior' or ‘deviant’. This rationalisation of ‘otherness’ manifested itself in evolutionism and eventually eugenics policies in the late nineteenth and early twentieth century. At this point, all individuals become susceptible to systematic categorisation against a norm driven by a Western, white, patriarchal, able-bodied, middle-class ideal (Davis 1997).

For the Deaf Community, the construction of deafness as a disability was consolidated during this same period when hearing loss became clinically defined and pathologized, and sign language became problematic (Baynton 1996, Branson and Miller 2002). Inspired by evolutionism, colonialism and the xenophobia sparked by increased immigration, deaf education began to focus not on knowledge acquisition, but on spoken language development in an attempt to normalize, assimilate, and thus 'raise' deaf people to an elevated 'hearing' way of being (Branson and Miller 2002, Baynton 1996). Normalization through speaking and listening became a driving force in deaf education. Sign language became almost extinct from deaf education and children were punished for its use. Teachers who were themselves deaf were made redundant and replaced with hearing, speaking teachers. Students who could not acquire speech were labelled ‘oral failures’ and were often segregated and relegated to special classes within institutions for deaf children (see Griffey 1994 for an account of the oralist system in Ireland.). So, the process of institutionalisation by the middle of the twentieth century was highly ideological, using spatial processes only as a means to an end, promoting the normalization of deaf bodies through speech and listening skills.

This system continued throughout the twentieth century until the 1970s which saw a resurgence in the use of sign language giving rise to the bilingual-bicultural movement in deaf education (Lang 2005). However, technological advances in the 1980s and 1990s, including improvements in digital hearing aids and the arrival of cochlear implantation[5] has once again seen a refocus on spoken language acquisition in the educational context. This has been accelerated by mainstreaming policy where deaf children, surrounded by hearing peers, are embedded within a system which ‘it can be contended … is institutionally ableist, being underpinned by the assumption of a “normally developing child”, and locating any “deviation” from this norm within the individual child, rather than examining socio--spatial processes of disablement in schools’ (Holt 2003). For deaf children, this deviation from the norm focuses on their ability to speak and the mainstream environment is viewed as providing greater opportunities to acquire that speech and simultaneously fewer opportunities for that speech development to be 'hindered'[6] by sign language. Subsequently, mainstreaming as it is currently practised in Ireland remains heavily influenced by the medical model, a fact which Branson and Miller highlight for its failure:

> The failure of mainstreaming for deaf people is seen to stem basically from the fact that they are mainstreamed in terms of a medical model of deafness. Despite the overt opposition to the use of clinically based assessments and, thus, to the use of medical models of "disability," even the most radical integrationists continue to define deafness as a pathology, as a lack rather than as a cultural difference based in a linguistic difference. Given the overriding ideals of the mainstreaming movement, the mainstreaming of deaf students is a blatant contradiction (2002)

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[5] A cochlear implant is a surgically implanted device which enables those with sensorineural deafness to access sound. It must be complemented by intensive speech and language therapy or audio-verbal therapy for language acquisition to proceed.

[6] There is little to no evidence to support the claim that sign language hinders spoken language development (Powers *et al*, 1998). Nonetheless, it is a commonly used discourse in the medical and educational fields that sign language will make children ‘lazy’ in spoken language acquisition, a claim which has seen the deliberate denial of sign language to deaf children.

It is for this reason perhaps that there is such reluctance towards mainstreaming from the Deaf Community. As Baynton observed:

> [t]he angriest objection to mainstreaming from deaf people is that in the name of liberating children from their supposed "isolation" in the deaf community, a true and potentially devastating isolation is risked. In the name of inclusion in "the" community, deaf children are frequently denied true inclusion in any community. For the sake of an abstraction known as the "mainstream," deaf children are denied the solid and tangible fellowship, culture, language, and heritage of the deaf community.(1996)

Mainstreaming, as opposed to an opportunity for meaningful inclusion with hearing peers, is instead viewed as the final stage of normalisation, begun in the nineteenth century with medicalisation of deaf bodies, continued through the twentieth century with pure oralism, and approaching completion in the twenty first century through surgical intervention and assimilation with hearing peers. Thus, sentiments against mainstreaming are common from the Deaf Community with Crean (1997) blaming mainstreaming for ‘destroying the embryo of the Deaf Community’ while Ladd states that ‘forceful clumsy attempts to mainstream not only deny the facts about being deaf but destroy much that deaf people and their friends have worked so hard to create, and may in the last resort to be seen as genocidal’ (in Branson and Miller 2002).

Mainstreaming and the Medical Model

This persistence of the medical model, in spite of calls to the contrary from the Deaf Community (Padden and Humphries 1988, Bahan 2008, Bienvenu 1991, Lane 2002, Lane et al. 1996) is no doubt contributed to by the fact that 90 per cent of deaf children are born to hearing families for whom their first encounter with deafness is constructed through the clinical gaze of the medical model. In Ireland as elsewhere, since diagnosis[7] occurs through the medical system, the professionals to whom parents turn during this time include audiologists, ear nose and throat specialists, and general practitioners. Immediately after diagnosis, families in Ireland with deaf children also receive a referral to the Visiting Teacher Service, an itinerant service provided by the Department of Education and Science to assist with educational intervention. Subsequently, these professionals play a large part in steering early intervention and educational placement with deaf children laying much of the groundwork for mainstreaming. Both medical and educational professionals often promote interventions which focus on ameliorating hearing loss and encouraging spoken language development indicating that they are embedded within a medical model of deafness. For example, the first service provided to all of the children involved in this research was amplification in the form of hearing aids or cochlear implants. Were this early intervention to focus on the social model of deafness, instruction in Irish Sign Language as well as access to the Deaf Community would be provided.

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[7] While the term diagnosis brings with it a pathological assumption, it is used instead of the social model favoured ‘identification’ here to highlight that the process is a medicalised one.

However, it became clear during the course of this research that it is not uncommon to find that parents are not informed of the benefits of using Irish Sign Language as a communication option with their deaf children. In fact, a negative discourse often surrounds Sign Language and parents are actively warned against its use. For example, over 25 per cent of the parents interviewed for this study were unaware at the time of the interview that there was an Irish Sign Language home tuition service available through the Department of Education and Science. In contrast, all of these parents were aware of and availing of audiology and speech and language therapy services. Of the 75 per cent of parents who knew about the Irish Sign Language home tuition service, most had found out through their own research, and only one parent had been informed of the service by her Visiting Teacher. Furthermore, several parents reported being discouraged from using the service when they raised the issue with medical or teaching professionals:

> Mother: They said to me that they were against Chris[8] and Ellen getting Sign Language because he is still gaining, he is still trying to gain language and it could set him back a lot, that's what the new teacher for the deaf was telling me,
>
> Principal Investigator (PI).: that it would set him back?
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> Mother: yeah, she said it could. Especially because Chris is relying a lot on lip-reading, that the grammar can just go straight downhill, that they just go from here (gestures downwards), she said definitely not at the moment. (Parent 02).

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[8] All names of participants have been replaced with pseudonyms.

Sign Language, instead of being upheld as a valuable mode of language acquisition for deaf children is instead labelled as a ‘crutch’, making children ‘lazy’ in their use of speech and causing deterioration in English grammar. While this early intervention often occurs in the preschool years, it paves the way for mainstreaming which is seen as complimentary to spoken language acquisition since deaf children are surrounded by hearing, *speaking* peers from whom they can learn. Indeed, many parents (in particular those whose children have cochlear implants) spoke of their children being under instruction in mainstream classes, not for educational or social reasons, but specifically to optimize their spoken language development:

> So they want Amazu and Adanna to be in the mainstream, especially Adanna … because at that age they believe you will pick up more sign language, [and] … if they are doing the implant they won't want you to sign. (Parent 15)

Adanna’s resource teacher reflected on her psychological report and its recommendations:

> Teacher: [the psychologist], because the brain shuts down to language acquisition at seven the – [psychologist] wants them as much as possible in – in mainstream
> PI: mmm
> Teacher: so that was her reason for…
> PI: okay it’s really for speech development then?
> Teacher: it’s for speech development yeah. (Professional 10 – unit resource teacher).

This becomes apparent in the adaptations provided to mainstream schools to ‘accommodate’ deaf children.

The most common adaptation is the use of a soundfield system or radio-aid which amplify sound for the deaf child. This is accompanied by speech and language therapy (which often results in absenteeism from school) to assist deaf children to acquire speech. Children may also be seated optimally for lipreading and viewing the blackboard. However, techniques common among the Deaf Community such as attention-calling, careful turn-taking to ensure that no one speaks when the deaf student is not watching and that the deaf student is involved in all relevant interactions are not so carefully implemented. My field notes from an observation of Marie in her classroom note:

> The speed of interaction in the classroom is very fast. There are a lot of changes in topics, even within one exercise. A lot of incidental learning is used. For example, they did an exercise on a weather map of Ireland. Eoin [class teacher] asked the students to name some of the counties in Northern Ireland. This was not part of the exercise, but instead an improvised moment of learning for the students. However, Marie was not aware of the change in topic, the microphone from the soundfield system was not used for the answers, and it is unlikely that she picked up the information covered during those brief moments. During these ‘incidental learning’ moments, the vast majority of the class raised their heads from their books and instigated eye contact with teacher and with each other.

> There were many hands and the air and several students call out the answer. They seem to know that this learning process is outside of the book. However, Marie remained focused on her book, following the sequence of questions there. When Marie notices the other students answering questions, she puts her hand up too. However, when Eoin calls on her to answer, she does not know what the question is. This suggests, to me, that she does not follow a lot of these 'incidental learning' moments when the topic of discussion has moved away from the sequence of questions in the book. (Field notes).

While Marie is physically present for the exercise, there is insufficient adaption of the teaching strategies used to fully include her in the lesson. In an environment sensitive to deaf awareness, Marie's attention would be gained before such an exercise. Similarly, in an environment where several deaf students are taught together and a deaf-aware teacher is employed, specific strategies would be used to maintain all students' attention for such interactions, such as knocking on the table so it vibrates, flashing lights, or getting students to tap each other on the shoulder to gain attention.

However, due to the complementary nature of speech acquisition and mainstreaming, segregating, or rather *congregating* deaf children together in specialized classes or units is seen to pose a threat to the development of spoken language. Speaking in relation to units for deaf children, one parent observed:

> Parent: You see that's where I'd be afraid, the sign [language].
>
> PI: Yeah, what would you be afraid of?

> Parent: My main worry there – my main worry would be none of them are speaking properly
>
> PI: Mmm
>
> Parent: So how can they learn from each other? (Parent 04).

As a result, the historical institutionalisation of deaf children in residential schools is now viewed as a threat to the normalising goals of the medical model. For the Deaf Community, while the residential schools may symbolize an era of oralism and segregation from their hearing communities, they also represented the opportunity for congregating amongst their own, fostering the development of Sign Language and Deaf Culture (van Cleve and Crouch 1989). Institutionalisation, perhaps ironically, provided a valued path for resisting hegemonic medical discourses of deafness. Deinstitutionalisation, on the other hand, fragments the Deaf Community and threatens the very core of Deaf Identity by prioritising speech to the detriment of Sign Language. Subsequently, mainstreaming practice, while it may aim to deinstitutionalize deaf children is merely *re*institutionalising them in a new spatial arrangement which does little to challenge the medical view of deafness as a pathological condition and in fact may reinforce the medical model more than institutionalized settings did.

This medical model is epitomized by the high status afforded to speech, using it as a measure of success for mainstreamed deaf students. One unit teacher spoke of her group of students, some of whom were mainstreamed and one who wasn't:

> But the fact that the boys [who are mainstreamed] aren’t profoundly deaf, it’s not as if, you know, they’re able to talk, they can hear as well. Cormac is fine, but he obviously has problems with language so he wouldn’t be able for mainstream, he’d fall behind. (Professional 13 - unit teacher)

For those who 'fall behind', sign language is often implemented as a last resort and the schools for the deaf may be recommended for second level owing to their inability to cope in the (oral) and mainstream (Powers et al. 1998), reinforcing the image of speech as success and sign language as failure in deaf education. One student, diagnosed with a mild learning disability who was struggling with literacy fell into this category:

> Overall, I don’t think he’d do well in a mainstream school. I really don’t think he would and I think his education would go down, I think for him, life skills would be more important for him. (Professional 13 - unit teacher)

Thus, the mainstream system resorts to the medical model of blaming the individual impairment when integration with hearing peers is not successful. As one teacher remarked, ‘Em, his speech was a problem last year, very difficult to understand. Most of the time, unless it was something that was very much in context, I couldn't understand him at all’ (Professional 15 - mainstream classroom teacher).

One noticeable exception to this was in the case of a school with a unit for deaf children, where a bilingual policy had been implemented in the school with all hearing children learning Sign Language. This was quite a unique situation and when asked about interactions between deaf and hearing students, the teacher blamed limited interaction between deaf and hearing students on the communication skills, not of deaf children, but their hearing peers:

> P.I: Do they interact a lot with the hearing students, like even at lunchtime or do they tend to stick…
>
> Teacher: They would, now they're inclined, to be honest, to keep to themselves, but my 6th class, my older kids have made a lot of an effort to play with the mainstream children. The mainstream children would know a lot about the deaf children, so it depends as well, some mainstream children would be a lot more communicative and would risk more in trying to communicate with them. (Professional 14 – unit teacher).

In informal discussion with the deaf children from this school, they confirmed that they preferred to play with other deaf children, but only because they didn't have the patience for their hearing schoolmates' slow signing, but that they appreciated their efforts nonetheless. Structured programmes within this school assisted deaf and hearing children in their interactions and, as was noted from the teacher's comment above, as they spent more meaningful time together, their quantity and quality of interactions improved. This indicates that when mainstreaming is carried out in a manner sensitive to deaf children's linguistic needs and with respect to Deaf Culture, it can indeed show benefits.

Conclusion

In her examination of inclusion and exclusion of children with mind/body differences in primary schools in the UK, Holt (2003) argues that ‘inclusion, rather than signifying a common meaning between educational practitioners, maybe identified as an ambiguous social-spatial construct, evoking a variety of meanings for individuals in different settings, although some shared group understandings may exist’. For deaf children in the Republic of Ireland, there seems to be a shared group experience whereby mainstreaming is synonymous with spoken language acquisition and interaction with peers based on adapting the deaf child. Owing to the lack of Sign Language and Deaf awareness training, the deaf student is expected to assimilate, accessing the curriculum with adaptations geared towards the child such as audiological treatment of the built environment and personal amplification assisting the child to hear, and speech and language therapy assisting the child to speak. Adaptations among the classroom, curriculum, school structure, teacher, and hearing pupils, in the Irish context at least, are less common. In such a system, the ability to speak becomes synonymous with success, and failure means reverting to Sign Language and schools for the deaf. Subsequently, the mainstreaming movement in the Republic of Ireland as it relates to deaf education is merely a continuation and indeed progression of the institutionalisation project which sought to ‘cure’ deaf children so they could integrate with hearing society. It is therefore not sufficiently a process of deinstitutionalisation, but rather as Branson and Miller (2002) highlight a "blatant contradiction" whereby children enter into a process of re-institutionalisation, continuing to be pathologized under a medical model. The mainstream environment, far from challenging pathological views of deafness is reinforcing this medical model in that it is seen as a valuable opportunity to foster spoken language acquisition by surrounding deaf children with their hearing peers.

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