HEALTH EDUCATION FRAMEWORK

FOR CALIFORNIA PUBLIC SCHOOLS

Kindergarten Through Grade Twelve

Chapter 7
Access and Equity

Adopted by the California State Board of Education
May 2019

Published by the California Department of Education
Sacramento, 2021

Access and Equity

CHAPTER 7

California's Diversity

The primary goals of the health education standards are to help all California students develop lifelong healthy behaviors, achieve the highest level of academic potential, and improve health literacy. Achieving these goals requires that all teachers, professional learning staff, administrators, and district leaders share the responsibility of ensuring health education equity for populations of learners who experience health disparities or are particularly vulnerable to academic inequities in health education.

California's children and youth bring to school a wide variety of skills and abilities, interests and experiences, and vast cultural and linguistic resources from their homes and communities. California students represent diverse ethnic and religious backgrounds and live in different familial and socioeconomic circumstances (US Census Bureau 2018). The greater the diversity in classrooms and schools, the richer the health education experience and the more assets upon which teachers may draw to enrich the health education experience for all. At the same time, the more diverse the classroom, the more complex the teacher's role becomes in providing high-quality instruction that is sensitive to the needs of individual students and leverages their particular assets. In such multifaceted settings, the notion of shared responsibility that includes a deeper understanding of the health education standards and its application to real-life situations is critical. Teachers, administrators, specialists, expanded learning leaders, parents, guardians, caretakers,

families, school support staff (such as school counselors, school nurses, and school social workers), community partners (such as school-based health centers), and the broader school community need the support of one another to best serve all students.

With so many languages other than English spoken by California's students, there is a rich tapestry of cultural, linguistic, ethnic, and religious heritages students can share (US Census Bureau 2018). California students have a range of skill acquisition and structural circumstances that impact their lives and learning. Highlighted below are some groups of students for whom it is important to acknowledge both the resources and perspectives they bring to school, as well as the specific learning needs that must be addressed in classrooms for all students to receive vital health education. These groups are identified so that schools and districts make critical shifts to ensure educational access (the opportunity for quality health education for all students) and equity (fair, unbiased, and impartial treatment of all health education students) for all students. The following groups of students are discussed in this chapter:

- Students identified as vulnerable
- Students who are English learners
- Students who are standard English learners
- Ethnically and culturally diverse learners
- Students who are migrants
- Students living in poverty and students experiencing homelessness
- Foster youth
- Students who are advanced learners and gifted learners
- Students who identify as lesbian, gay, bisexual, transgender, or questioning
- Students with visible and nonvisible disabilities
- Students who have experienced trauma

For an expanded discussion on California's diverse student population, including biliterate students and students who are deaf or hard of hearing, see the *English Language Arts/English Language Development Framework for California Public Schools* (California Department of Education 2015).

Though presented separately, these populations are not mutually exclusive; many students' identities intersect with multiple groups. According to the December

2017 California Special Education Management Information System Software, 71 percent of students up to age twenty-two with visible and nonvisible disabilities are in one or more of the Local Control Funding Formula student groups (CASEMIS 2017). It is critical that county office of education leads, administrators, and educators utilize this data to guide their planning and provision of services to their diverse student populations. In particular, teachers must be equipped with resources and training that will enable them to engage and prepare all of their students for college, career, and beyond. Teachers, administrators, and curriculum designers can inform themselves about particular aspects of their students' backgrounds, keeping in mind that these identities may overlap, intersect, and interact. Teachers should take steps to understand their students as individuals and their responsibility for assessing their own classroom climate and culture. Teachers should consider referring and navigating students in need of services to appropriate professionals, including the school nurse, administrators, school counselors, school psychologists, and school social workers, as available. When appropriate, teachers should also refer students to health care services with little to no cost in their community, regardless of their immigration status.

Universal Design for Learning

Universal Design for Learning (UDL) is a research-based framework for providing multiple pathways and supports so that students can take an individualized approach to meeting common learning goals. UDL is a proactive method that reduces the need for follow-up instruction and the need for alternative curriculum. The UDL principles and guidelines support the inclusion of every student in health education. This section provides an overview of UDL and guidance on applying the UDL principles, guidelines, and checkpoints to curriculum design and lesson planning.

Many lessons and curricula are planned to fit the needs of an average student. However, decades of research in cognitive neuroscience proves that all learners are varied and there is no such thing as an "average" student (National Center on Universal Design for Learning 2010). Recent advances in neuroscience provide a different understanding of learner variability and place learners on a continuum based on their individual differences. These differences are predictable and the variability that exists across every student can be anticipated and addressed in the initial design stage of instruction (Meyer, Rose, and Gordon 2014). Instead of

trying to fit student learning abilities into the middle of a bell curve, curriculum designers and teachers can "plan for expected variability across learners and provide curriculum that has corresponding flexibility" at the very beginning of the instructional cycle (Meyer, Rose, and Gordon 2014, 10). At the beginning of the instructional cycle, planning for variances in student abilities, interests, and needs provides flexibility to amplify students' natural abilities while reducing barriers to access the content being taught. Even so, there will be instances in which students require additional supports to reach instructional goals and teachers are advised to use formative assessment data to plan to differentiate instruction (Tomlinson 2014).

In UDL, teachers provide students opportunities to think strategically, set goals, and reflect on their performance at the beginning of learning. Educators are advised to utilize the UDL Framework to design universally accessible learning environments, including curricula, instructional supports, and the physical and emotional environment (CAST 2018). The UDL Framework is organized around the three principles of UDL, which are: (1) provide multiple means of engagement; (2) provide multiple means of representation; and (3) provide multiple means of action and expression (Meyer, Rose, and Gordon 2014). The principles of UDL emphasize the importance of curriculum designers and teachers providing multiple means of engagement (the why of learning), representation (the what of learning), and action and expression (the how of learning). Through the UDL framework, the needs of all learners are identified and planned for at the point of first teaching.

In addition to the three principles of UDL, CAST provides guidelines and checkpoints that can be used as a guide for planning instruction that addresses learner variability. The UDL Framework lists nine guidelines, and they "emphasize areas of learner variability that could present barriers, or, in a well-designed learning experience, present leverage points and opportunities for optimized engagement with learning." (Meyer, Rose, and Gordon 2014, 111). Under the guidelines, CAST suggests specific practices for implementation checkpoints. These checkpoints are a good place to begin when applying the practice of UDL but are not the only strategies that could be used in a universally designed learning environment. Visit the CAST website for additional information on how to apply the guidelines and checkpoints when planning instruction and assessment. The guidelines and checkpoints from the 2018 update of the UDL Framework are listed in the table below.

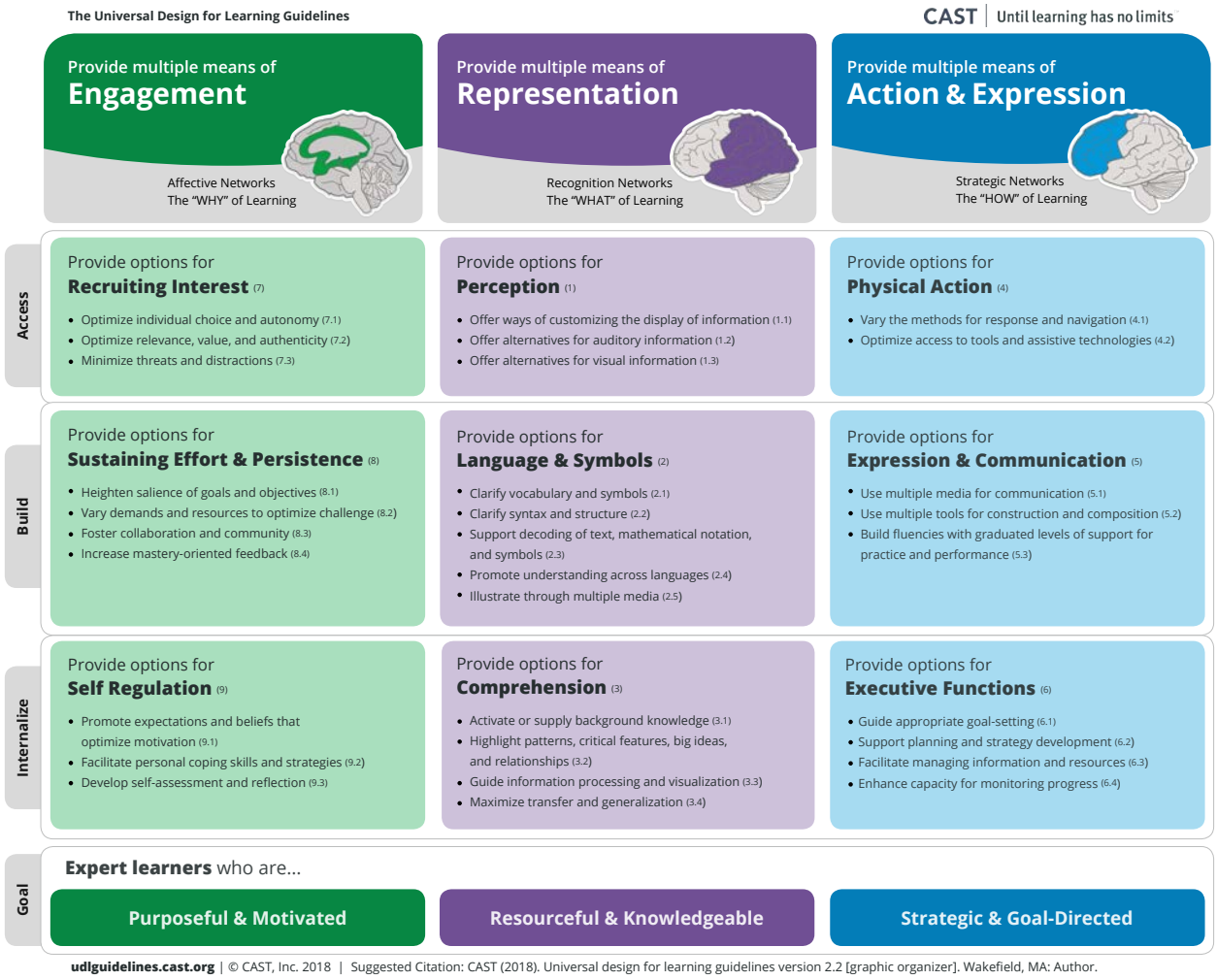
Universal Design for Learning Guidelines and Checkpoints

Principles *Provide multiple means of ...*	**Guidelines and Checkpoints** *Provide options for ...*
I. Engagement Provide multiple ways to engage students' interests and motivation.	**1.** Recruiting interest (Checkpoints 7.1, 7.2, 7.3) **2.** Effort and persistence (Checkpoints 8.1, 8.2, 8.3, 8.4) **3.** Self-regulation (Checkpoints 9.1, 9.2, 9.3)
II. Representation Represent information in multiple formats and media.	**4.** Perception (Checkpoints 1.1, 1.2, 1.3) **5.** Language and symbols (Checkpoints 2.1, 2.2, 2.3, 2.4, 2.5) **6.** Comprehension (Checkpoints 3.1, 3.2, 3.3, 3.4)
III. Action and Expression Provide multiple pathways for students' actions and expressions.	**7.** Physical action (Checkpoints 4.1, 4.2) **8.** Expression and communication (Checkpoints 5.1, 5.2, 5.3) **9.** Executive functions (Checkpoints 6.1, 6.2, 6.3, 6.4)

Source: *Adapted from CAST (2019).*

The figure below provides an outline of UDL Principles and Guidelines that health education teachers can use to inform their curriculum, instruction, and assessment planning. Specific examples of applying UDL in the health education classroom are provided later in this chapter in the Accommodations and Modifications for Students with Visible and Nonvisible Disabilities section. However, the application of UDL benefits all students, not just those with visible and nonvisible disabilities. More information on UDL principles and guidelines, as well as practical suggestions for classroom teaching and learning, can be found at the National Center on Universal Design for Learning YouTube channel and the CAST website at https://www.cde.ca.gov/ci/he/cf/ch7.asp#link1. The 2018 UDL Framework is provided in the figure below.

Universal Design for Learning Framework



Long Description of Universal Design for Learning Framework is available at https://udlguidelines.cast.org/.

Source: *CAST (2019).*

Culturally and Linguistically Responsive Teaching

To create truly equitable classrooms, schools, and districts—ones that support all students' achievement—teachers and all school staff should continuously strive for social justice, access, and equity. This requires teachers, support staff (such as school counselors, school nurses, and school social workers), specialists, administrators, and community partners, and school-based health centers to adopt a stance of inquiry toward their practice and to engage in ongoing, collaborative discussions with their colleagues about challenging issues, including race, culture, language, and equity. The National Center for Culturally Responsive Educational Systems highlights the importance of creating a shared responsibility for cultural responsiveness:

> Culturally responsive educational systems are grounded in the belief that we live in a society where specific groups of people are afforded privileges that are not accessible to other groups. By privileging some over others, a class structure is created in which the advantaged have more access to high-quality education and later, more job opportunities in high status careers. This leads to socio-economic stratification and the development of majority/minority polarity. We can turn the tide on this institutionalized situation by building systems that are responsive to cultural difference and seek to include rather than exclude difference. Moreover, culturally responsive educational systems create spaces for teacher reflection, inquiry, and mutual support around issues of cultural differences. (National Center for Culturally Responsive Educational Systems 2008, 15)

Culturally and linguistically responsive teaching and equity-focused approaches emphasize validating and valuing students' cultural and linguistic heritage while also ensuring their access to comprehensive health education.

Culturally and Linguistically Responsive Teaching

Culturally and linguistically responsive teaching can be defined as using the cultural knowledge, prior experiences, frames of reference, and performance styles of ethnically diverse students to make learning encounters more relevant and effective. It teaches to and through the strengths of these students. It is culturally validating and affirming. Along with improving academic achievement, these approaches to teaching are committed to helping students of color maintain identity and connections with their ethnic groups and communities. It helps develop a sense of personal efficacy, building positive relationships and shared responsibility while they acquire an ethic of success that is compatible with cultural pride. Infusing the history and culture of the students into the curriculum is important for students to maintain personal perceptions of competence and positive school socialization.

Source: *Los Angeles Unified School District (2012, 86).*

To ensure access and equity for culturally and linguistically diverse learners, educators must adopt an asset orientation toward all students. This includes the school community's open recognition that students' ethnicities, religious backgrounds, home cultures and experiences, primary languages and home dialects of English (e.g., African American English), family composition, gender expression, and other aspects of students' identities are viewed as *resources*, valuable in their own right and useful for deep learning. To ensure culturally and linguistically responsiveness, the following six daily essential practices are recommended.

Six Daily Essential Practices for Culturally Responsive Teaching

1. **Create a Culturally Sustaining Environment.** Create a positive and welcoming classroom environment that exudes respect for—and promotes the sustainment of—cultural, linguistic, and all types of diversity. For example, when the school year begins, create a class-generated list of norms that encourages respect for diversity, collaboration, support, patience, empathy, and kindness. Establish a classroom culture where terms such as "unique" are used in lieu of disrespectful and shaming terms such as "weird" or "gross" to ensure cultural sensitivity and inclusion (Adapted from LeMoine [1999]; McIntyre and Turner [2013]; Moll et al. [1992]).

2. **Connect with Students as Whole Individuals.** Know each student by name, and take the time each day to greet students so they feel welcome in school. Do not make assumptions about students based on their perceived culture or single students out as "representative" of a culture, but instead spend some time understanding the multiple layers of students' identities, particularly if their backgrounds differ from your own, including their cultural, linguistic, and disability assets and how individual students interact with their primary languages, home cultures, and various communities.
3. **Promote Pride in Students' Cultural and Linguistic Heritage.** Use students' primary languages or home dialects of English, as appropriate, to acknowledge them as valuable assets and to support all learners to engage meaningfully with the curriculum. Initiate open dialogue with students on their cultural experiences and practices with health subject matter and content. Examples may include comparing western medical practices to traditional medical practices, or healthcare in one's home country to healthcare in the United States. Traditional health beliefs, practices, and values of individuals should be recognized and integrated in teaching practice (Adapted from Gay [2002]; Ladson-Billings [2014]; Paris [2012]).
4. **Prioritize Culturally Relevant Texts and Topics.** Use texts that accurately reflect students' ethnic, cultural, linguistic, and familial backgrounds, as well as other variables that contribute to their identities, such as gender expression, so that students see themselves as belonging and valued in the school curriculum. It is especially important to deliberately include culturally relevant topics and texts—and to celebrate the contributions of historically marginalized cultures to health education topics—since these contributions are typically left out in school curricula (Adapted from LeMoine [1999]; McIntyre and Turner [2013]).
5. **Address Racial Inequities and Language Status.** Address implicit and explicit racial bias, and if racially-charged topics occur, do not ignore them. Students may benefit from a class meeting or seminar in which they have an opportunity to discuss issues dealing with racial inequities or dynamics as they relate to health education topics. In addition, address language status issues and emphasize that multilingualism and multidialectalism are assets. Establish a classroom climate where students are not discouraged from using their primary languages or home dialects of English (e.g., African American English, Chicanx American English) but instead encouraged to add new

language and ideas to their existing repertoires (Adapted from Harris-Wright [1999]; Schwartz [2014]).

6. **Support Students' Development of Academic English.** Focus on intellectually rich and engaging tasks that allow students to use academic English in authentic and meaningful ways. Make transparent to students how academic English works to make meaning in health education topics. This includes helping students to develop *register awareness* so that they understand how to shift the type of language they use, based on purpose, topic, and audience (for example, a class conversation versus an academic essay). Making the "hidden curriculum" of language visible in respectful and pedagogically sound ways is one way of ensuring the educational civil rights of culturally and linguistically diverse students (Adapted from Christie [1999]; Delpit [2006]; Schleppegrell [2004]; Spycher [2017]).

The following sections provide descriptions of student populations in California who especially benefit from instruction based on UDL and equity-oriented practices, programs, and policies.

Students Identified as Vulnerable

Many of the mentioned student populations may be considered particularly vulnerable to academic inequities, but their vulnerability also puts these students at a higher risk for abuse, exploitation, and other dangerous situations. Due to multiple structural inequalities, students with visible and nonvisible disabilities, in foster care, living in poverty, who identify as LGBTQ+, those experiencing mental health issues, or other populations are especially at high risk for homelessness, unhealthy relationships, sexual or emotional abuse, and sex trafficking. Careful attention should be paid to these and other vulnerable populations who may need additional support in achieving academic goals, developing health enhancing behaviors, and accessing support and resources.

Students Who Are English Learners

Students who are learning English as an additional language, or English learners (sometimes referred to as "ELs"), come to California schools with a range of cultural, linguistic, and educational backgrounds, proficiencies in English,

and experiences with formal schooling and content learning (both formal and informal). Many English learners in California were born in the United States. Some enter the United States in late elementary through high school and may have strong academic backgrounds, similar to their native-English speaking peers in terms of content knowledge, or have studied English in their home countries before emigrating. Other English learners have had disrupted educational experiences, and still others arrive in California schools unaccompanied by their families due to a variety of reasons. English-learner students are a heterogeneous group with one thing in common: they are simultaneously learning English and academic content. This unique need requires all health education teachers of English-learner students (e.g., the elementary grade levels classroom teacher, the secondary health education teacher) to understand English language development in the context of health education. A definition of English learner status in California is provided below:

English Learners Defined

English learners are defined by the California Department of Education as:

… those students for whom there is a report of a primary language other than English on the state-approved Home Language Survey **and** who, on the basis of the state approved oral language (kindergarten through grade level twelve) assessment procedures and literacy (grade levels three through twelve only), have been determined to lack the clearly defined English language skills of listening comprehension, speaking, reading, and writing necessary to succeed in the school's regular instructional programs. (California Department of Education 2019)

Critically, schools and districts should ensure that English-learner students are not deprived of health education learning opportunities, for example, through placement in an English language development (ELD) class instead of a health course. English-learner students have a right to, and a need for, quality health education. It is the responsibility of each teacher to be aware of the cultural and linguistic assets and background experiences of English-learner students, and to meet their specific language learning needs. Using the *California English Language Development Standards* to plan lessons and units, and outline formative assessment practices and evaluation of student work, supports teachers with this responsibility.

With appropriately scaffolded and differentiated instruction from their teachers, effective leadership and programmatic support from principals and other site administrators, and appropriately designed programs, English learners at all levels of English language proficiency are able to engage in intellectually challenging, health content- and language-rich instruction so they can develop the advanced levels of English and content knowledge necessary to adopt and engage in healthy behaviors throughout their lives. It is important for teachers to remember that English-learner status is intended to be temporary and not long-term.

Included among the goals of a robust, rigorous, and comprehensive educational program for students who are English learners are to ensure (1) that they become proficient in English as rapidly as possible, and (2) that they have the opportunity to simultaneously develop high levels of academic English, deep content knowledge, and the skills and dispositions they will need as they progress through grade levels. This is why, to fully include English learners in health education instruction, all health education teachers of English learners should use—in tandem—the California English Language Development standards (CA ELD standards, found in *California English Language Development Standards*), the health education standards, and the California Common Core State Standards (CA CCSS for ELA/Literacy, found in *California Common Core State Standards for English Language Arts and Literacy in History/Social Science, Science, and Technical Subjects*).[1] The CA CCSS for ELA/Literacy and the CA English Language Development Standards emphasize the knowledge and competencies students need to develop to understand, communicate about, and practice healthy behaviors.

Ensuring that English learners have full access to comprehensive health education can only be accomplished through five ways:

1. Planning lessons and units carefully
2. Understanding the cultural and linguistic assets students bring to the classroom
3. Observing what students are doing and saying during instruction and activities

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1 See the *California English Language Development Standards* and the *CA CCSS for ELA/Literacy* to determine specific standards for each grade level, and the *English Language Arts/English Language Development Framework* (*ELA/ELD Framework*) for detailed guidance on how to complementarily implement these standards (California Department of Education 2013; California Department of Education 2015).

4. Reflecting on how English learners engage with particular approaches to instruction
5. Refining and adjusting instruction, based on observation, reflection, and assessment, as necessary

The focus on active learning, applied skills, and behaviors—not to mention the high-interest topics and potential for language-rich disciplinary discussions—makes health education classes ideal learning environments for *integrated* English language development (see table below). For this reason, health education teachers should work closely with site and district ELD specialists to ensure that their classrooms serve English-learner students' English language development needs, in concert with an opportunity to learn health concepts and skills. Likewise, as available, ELD specialists should work closely with health education teachers to understand how to design and provide appropriate instruction on health education topics during designated English language development (see table below for a definition of integrated and designated ELD).

Integrated and Designated ELD

Integrated ELD	Designated ELD
Health education instruction with integrated ELD (throughout the day)	Specialized instruction for English learners at a *targeted* time, based on English language proficiency levels and English language learning needs
Integrated ELD is provided to English learners throughout the school day and across all subjects by their teacher. The CA ELD standards are used in tandem with the content standards in health education and/or other subject areas being taught to ensure students strengthen their abilities to use English as they simultaneously learn content through English.	A protected time during the regular school day. Teachers use the CA ELD standards as the focal standards in ways that build *into and from health education and/or other content instruction* to support English learners developing critical language needed for health education learning in English.

When designing health instruction with integrated ELD, educators should carefully consider the English language proficiency levels of their English learners and determine how the skills and concepts from the CA ELD standards can support and provide access to the practice and mastery of the health education standards. Educators can provide opportunities for English learners to access health content by planning for targeted scaffolding to promote extended academic discourse; comprehension of complex texts; creation of quality written texts, oral presentations, or multimedia projects; and, ultimately, deep learning of critical health subject matter. The framing questions (below) provide a tool for planning that teachers may find valuable.

Framing Questions for Lesson Planning

Framing Questions for All Students

- What are the big ideas and culminating performance tasks of the larger unit of study, and how does this lesson build toward them?
- What is/are the learning target(s) for this lesson, and what should students be able to do at the end of the lesson?
- Which cluster of health education standards and CA CCSS for ELA/Literacy does this lesson address?[2]
- What background knowledge, skills, and experiences do my students have related to this lesson?
- How complex are the concepts and skills?
- How will students express themselves effectively, develop language, and learn content in this lesson?
- What types of scaffolding, accommodations, or modifications will individual students need for effectively engaging in the lesson tasks?
- How will my students and I monitor learning during and after the lesson, and how will that inform instruction?

2 Note that the CA CCSS for ELA/Literacy applies to both K–5 and 6–12. Literacy standards for history–social studies, science, and the technical subjects are separated from ELA standards in grade levels 6–12.

Framing Questions to Add for English Learners

- What are the English language proficiency levels of my students?
- Which CA ELD standards amplify the health education standards for communication and analysis at students' English language proficiency levels?
- What language, including vocabulary, might be new for students and/or present challenges for understanding content?
- How will students interact in meaningful ways and learn about how English works related to the health education standards for accessing valid information and health promotion? The example below illustrates the integration of the health education standards (7-8.8.1.N, Health Promotion), the CA CCSS for ELA/Literacy, and the CA ELD standards in a writing assignment in which students make an argument for healthier food in the school.

VIGNETTE

Integration Example: Writing Arguments about Healthy Foods

Ms. G's middle school health education class is researching the benefits and costs of conventional and organic farming, and their culminating task will be a written argument for organic food choices at school. Ms. G has collaborated with the English language arts teacher and ELD specialist to create a unit that integrates health education, English language arts, and English language development. Over the course of the unit, the class has read informational texts and arguments about the topics, viewed documentaries on the history of farming and recent developments in sustainable and organic agriculture, and engaged in extended discussions about the topic. The students have orally debated the issues they researched, analyzed and evaluated the validity of written arguments on the topic, and learned relevant domain-specific and general academic vocabulary that supports their discussions and writing on the topic.

In their English classes, the students have analyzed the overall structure and organization of the arguments they were reading, and how to use powerful and effective language in the arguments they write. They also learned how to cite evidence and sources appropriately in both their English and health education class.

All of these activities were discussion based and student-centered. Students worked in pairs or small groups using norms for collaboration and with teacher guidance, such as modeling and explaining. Working in collaboration with the ELD specialist, Ms. G used the CA ELD standards to inform the ways in which her lessons would support students to interact in meaningful ways with the texts they were reading and with one another, as well as to understand how English works in arguments.

An example of one of the texts the students analyzed (an exemplar argument from one of Ms. G's students from a previous year) with the stages of the argument they identified and some of the language they explored is shown in the Student Writing Example section below (note that the type of argument the students wrote is an Opinion-Editorial text, which will sometimes allude to counterarguments, as seen following this example).

When Ms. G met with her cross-departmental team, she reflected that the type of writing her students were able to produce required time for students to learn and interpret the content in the articles they were reading; analyze and evaluate the content of the arguments; discuss and debate their ideas; and explore and analyze how language works in the arguments, which the students ultimately used as "mentor texts." She noted that her students learned skills to promote health in their school that they will be able to apply to an activity promoting community health. The teachers discussed how much their English-learner students' writing improved, compared to past years. Using this evidence, the teachers agreed that the use of the CA ELD standards in lesson planning resulted in students being in a better position to comprehend the content of the arguments they read and to produce arguments that supported their progress in health education.

As they discussed their next steps, the teachers agreed to continue to collaborate and use the standards in an integrated way to inform lesson and unit planning. They also decided to create "success criteria for writing arguments," based on the standards to make transparent what their writing expectations were, with the English language arts teacher taking the lead to develop the criteria. Ms. G, the English language arts teacher, and the ELD specialist planned to use the success criteria as a tool for evaluating students' writing and providing feedback to them.

Student Writing Example

Writing is the last skill to develop for any student. It is especially important for teachers to lay the foundation for oral language development—reading and listening skills—before writing a narrative. Below is a sample template to help English learners organize a written assignment.

Stages and Phases	The Text
Title	Our School **Should** Serve Organic Foods
Position Statement *Issue Appeal* *Concession to counterpoints*	All students who come to Rosa Parks Middle School **deserve** to be served safe, healthy, and delicious food. Organic foods are more nutritious and safer to eat than nonorganic foods, which are treated with pesticides. Our school **should** serve only organic foods because it is **our basic right** to know that we are being **taken care** of by the adults in our school. Organic foods **might** be more expensive than nonorganic foods, and this may prevent some schools from going organic. However, I believe that we **must** all work together to make sure we eat only the healthiest foods, and that means organic.
Arguments *Point A* *Elaboration*	Eating organic foods is safer for you because the crops are not treated with chemical pesticides like nonorganic crops are. **According to a recent study** by Stanford University, 38 percent of nonorganic produce had pesticides on them, compared to only 7 percent of organic produce. **Some scientists say** that exposure to pesticides in food is related to neurobehavioral problems in children, such as attention-deficit/hyperactivity disorder (ADHD). **Other studies show** that even low levels of pesticide exposure can remain in the soil and water for a long time and hurt us. I **definitely** do not want to take the risk of poisoning myself every time I eat lunch.

Stages and Phases	The Text
Point B Elaboration	Organic food is more nutritious and healthier for your body. **The Stanford University study also reported** that organic milk and chicken contain more omega-3 fatty acids than nonorganic milk and chicken. Omega-3 fatty acids are important for brain health and also **might** help reduce heart disease, so we **should** be eating foods that contain them. **According to Michael Pollan and other experts,** fruits and vegetables grown in organic soils have more nutrients in them. **They also say** that eating the fruits and vegetables close to the time they were picked preserves more nutrients. **This** is a good reason to get our school's food from local organic farms. Eating local organic foods helps keep us healthier, and **it** also supports the local economy. We **might** even be able to get organic crops more cheaply if we work with more local farms.
Point C Elaboration	Organic foods are **better** for the environment and for the people who grow the food. Farmers who grow organic produce do not use chemicals to fertilize the soil or pesticides to keep away insects or weeds. **Instead, they** use other methods like beneficial insects and crop rotation. **This** means that chemicals will not run off the farm and into streams and our water supply. **This** helps protect the environment and our health. **In addition,** on organic farms, the farmworkers who pick the food aren't exposed to dangerous chemicals that could damage their health. **This is** not only good for our school; **it** is something good we should do for ourselves, other human beings, and the planet.
Reiteration of Appeal	**To put it simply**, organic foods are more nutritious, safer for our bodies, and better for the environment. **But** there is another reason we should switch to organic food: When I bite into an apple or a strawberry, I want it to taste like the natural fruit and I do not want a mouthful of pesticides. Some people might say that organic is too expensive, but I say that we cannot afford to risk the health of students at this school by not serving organic foods. **Therefore**, we must find a way to make organic foods part of our school lunches.

Source: *Adapted from the* California English Language Development Standards *(California Department of Education 2014, 166).*

Long-Term English Learners

Long-term English learners (sometimes referred to as "LTELs") have been schooled in the United States for six or more years but have not made sufficient linguistic and academic progress to meet reclassification criteria and exit English-learner status (see *EC* sections 313.1(a) and (b) for a definition of long-term English learners). Fluent in social/conversational English but challenged by academic literacy tasks, long-term English learners may have difficulties engaging meaningfully in increasingly rigorous coursework.

California recognizes that long-term English learners face considerable challenges succeeding in school as the amount and complexity of the academic texts and tasks they encounter increases. Special care should be taken when designing instruction for long-term English learners, as instruction should focus on accelerating the simultaneous development of academic English and content knowledge to ensure that they are able to benefit from comprehensive health education. Health education coursework is one of the ideal disciplines to support long-term English learners in achieving this accelerated trajectory because of its high-interest topics and focus on disciplinary literacy, and its potential for group projects and real-world applications relevant to students' own lives (Fairbairn and Jones-Vo 2010). Every effort should be made to enroll and retain long-term English learners in such coursework, and to provide the appropriate support and motivation to ensure their success. All teachers who are responsible for health education and have students who are at risk of becoming long-term English learners should ensure students have full access to the positive identity development, social and emotional learning, and health awareness that are so critical to academic learning.

Students Who Are Standard English Learners

Standard English learners (sometimes referred to as "SELs") are students who are native speakers of English and whose home language differs in structure and form from so-called "standard English" and academic uses of English that are typically given higher status in schools (Los Angeles Unified School District 2012, 82).[3] Standard English learners may be less aware of the standard English structures and forms used in school since they use a *nonstandard* dialect of English in their homes and communities (LeMoine 1999; Okoye-Johnson 2011). The term *standard English* is used to identify one variety of English among many; it is the variety valued in school and used in academic texts.

Teachers can support their students in understanding the way English is used depending on audience, topic, content, mode of communication, and purpose for communicating (e.g., to argue, explain, describe, etc.). The way students use "everyday" language and home dialects interacting with their families or engaging in healthy behaviors with their peers is different from the type of language expected in certain academic tasks, such presenting or demonstrating a healthy behavior. An anticipated outcome of the CA Common Core Standards is that students go deeper into the content of what they are learning and develop an academic vocabulary in the content areas. By differentiating instruction and using the CA ELD standards, English learners will have greater success in learning the language and nuances of health education. It is also important for instructors to be sensitive to, and respectful of, families' cultural expectations and attitudes regarding health, while simultaneously looking for opportunities to engage families and students.

Supporting students to develop the language of health education is critical so that students can fully participate in deep learning about health topics, which often incorporate the language of advanced disciplines such as medicine, research, and cross-disciplinary subjects including science and mathematics. In addition, the

3 "So-called" is used intentionally to openly question the value judgment placed on the traditionally accepted term "standard English," which places one dialect of English above others, including those typically used in marginalized communities (e.g., African American English, Chicanx-English). The term "standard English" used here is not intended to imply that "nonstandard" dialects of English are incorrect or inferior.

discipline of health education often relies on developing effective communication skills (for example, using refusal skills). All students need multiple and varied opportunities to learn, practice, and self-evaluate in meaningful ways the applied practice of health education.

Explicit attention to the language of the discipline supports students' conceptual understandings and their ability to engage in deeper practice in health education. In addition, students may need explicit instruction in the norms of how to interact in extended academic discussions. These ways of interacting include initiating or entering a conversation, building on the ideas of others, respectfully disagreeing, and questioning assertions. All of these tasks that are integral to health communication are language- and literacy-intensive. To achieve equity and access in health learning environments, teachers need to find ways of supporting standard English learners (along with all other students) to develop this specialized language so they understand how and when to use the language appropriately (see Framing Questions for Lesson Planning).

Classrooms should be inclusive and "additive" spaces where students can use the language they bring from their homes and communities while they also develop new ways of using and applying the more specialized language and communication skills specific to the field of health education. Health can be a very personal subject for most students, inevitability leading to subjective reflection and contributions. For all students to engage in health education practices and skills, teachers should also establish classroom norms for inclusive student contributions and discourse.

The language students use when engaged in conversations about health education should be appropriate and inclusive. Students should be encouraged to express their *ideas*, regardless of the style of English in which these ideas are articulated. The purpose of facilitating students' engagement in health discourse is not to "correct" the student's language or compel students to use particular words or phrases, but to develop and enrich student language through its purposeful use in intellectually rich and meaningful experiences. Examples may be to individually "map" the student's informal or local community term with the medically accurate term, or provide an opportunity for open exchange of terminology commonly used for a health behavior, such as using Alcohol, Tobacco, and Other Drugs (ATOD).

With this focus on meaning and on language as a meaning-making resource, all students are supported to develop the ability to discuss various complexities of health content from nutrition and personal safety to mental health and sexual

health through their own perspective or lens. As students continue to engage in health communications, they will increasingly make informed decisions about any new technical or health-specific language they encounter when they read or employ in their discussions, presentations, and writing. The goal is to support all students to develop new ways of using language and to understand how to make intentional language choices so that they are able to flexibly shift "register" to meet the language expectations of a variety of health practices.

Because so much of health education learning occurs through oral and writing discourse (including discussions, presentations, role playing, dramatizations, and many different types of writing), these understandings about language diversity, including nuanced understandings of dialect differences, are critical for health education teachers to develop.

Ethnically and Culturally Diverse Learners

California has the largest number of racial and ethnic groups, with more Hispanics, Latinxs, and Asian Americans than any other state in the nation (US Census Bureau 2018). In addition, California enjoys a welcoming climate for religious diversity. Ethnically and culturally diverse learners are a broader population of students that include the students described above (English learners, long-term English learners, or standard English learners). These students may face unequal access to—and inequities in—health education because of the structural and social inequalities that currently exist in many school systems, such as implicit or explicit racism or religious intolerance. Being aware of the specific challenges to access and equity that face diverse learners and supporting their success in health education provides students with access to and equity in their overall learning, resulting in greater academic achievement (Basch 2014; CDC 2014).

Diverse learners may bring different values, practices, or customs from their home country or home life. Every effort should be made to ensure an inclusive and safe classroom environment that respects and celebrates the rich, important contributions ethnically and culturally diverse learners provide. Teachers and administrators should ensure systems and policies are in place to protect ethnically and culturally diverse learners from teasing, bullying, or victimization.

This information should be used to ensure culturally competent and sensitive teaching, but should **not** be misunderstood to mean that certain topics or standards are not appropriate or should not be taught. All students deserve a comprehensive standards-based health education, and although accommodations should be culturally appropriate, they should not be omissive.

Preparing a Diverse Health Workforce

The national health workforce, with less than 25 percent of health professionals representing a racial or ethnic group other than white, does not reflect the diversity of California's population (US Bureau of Labor Statistics 2019). For some sectors of health and healthcare, such as physicians, nurses, and physical therapists, the percentage can be even lower. Training a diverse workforce is a long-term process, beginning with students in the K–12 system and continuing into college. California is one of the states adopting various approaches to ensure an adequate health workforce with programs, such as the Health Careers Training Program, that award small grants to high schools to encourage underrepresented students to explore health careers through academic support, internships, career fairs, and Saturday academies. Research shows that under-represented students who receive support are more likely to deliver care in underserved communities once they are practicing providers (Goodfellow et al. 2017).

Students Who Are Migrants

According to the California Department of Education, "A child is considered "migratory" if their parent or guardian is a migratory worker in the agricultural, dairy, lumber, or fishing industries and their family has moved during the past three years" (2018). Migrant students represent a significant number of California's children and adolescents. The California Migrant Education Program is the largest in the nation and one out of every three migrant students in the United States lives in California (California Department of Education 2018). In the 2018–19 school year, there were over 78,947 migrant students between the ages of 3–21 attending California schools during the regular school year (CDE 2020).

Social and economic factors affect migrant families across California and the nation. Schools and districts should be aware of the background factors that may

affect the ways in which students from migrant families engage in school learning. Most importantly, teachers should become familiar with their migrant students' circumstances so they can attend to their students' particular learning needs.

One of the greatest challenges facing migrant students is access to and continuity of the services that are intended to meet their unique needs. The goal of California's migrant education program is to provide supplemental services and supports to migrant students so they can be ready for school, successful in it, and graduate with a high-school diploma. When families move, migrant students' educational progress is interrupted, which can be exacerbated if the family moves to an area where a migrant education program does not exist or if the migrant program does not identify students and provide them with services in a timely way. Not only do the students have an interruption in their education, but they also experience the interruption in services designed to help them overcome their unique challenges as migrant students.

Schools and districts are required to create and adhere to a systematic plan for identifying migrant students as soon as they enter their schools, and for immediately providing appropriate services so that migrant students' education is not further disrupted. Schools and districts do not need to ascertain student's immigration status. For more information and resources in meeting the needs of migrant students, search the California Department of Education Migrant Education Programs and Services, the California Department of Education Safe Havens Initiative, the Migrant Students Foundation, and the Colorín Colorado website.

Support for undocumented students is critical in helping them feel safe to focus on their education. The immigration status of students in California has been the subject of a variety of laws and legal challenges. Current law states that school-age children who reside in California must not be denied a free public education based on citizenship status. Educators and school support staff are often the first to witness the impact of the stress families face with undocumented status. Schools should be safe havens for all students. Schools can support undocumented students and families by creating a safe and supportive environment, understanding the resources available to undocumented students and families, and being open-minded and ready. For more information on Safe Haven Schools, visit the California Department of Education Safe Havens Initiative web page.

Students Who Are Socioeconomically Disadvantaged and Homeless

Nearly 20 percent of California's children and adolescents live in poverty—one of the highest percentages in the United States (Public Policy Institute of California 2019). Some students living in poverty are from families where parents, guardians, or caretakers are underemployed or are working one or more jobs. Some students living in poverty live in environmentally unjust circumstances—that is, their neighborhoods or communities are exposed to high levels of contaminated air, water, or soil. Some students living in poverty have also moved often with their families, changing schools multiple times, because of economic circumstances. Additionally, some are unaccompanied minors; some live on the streets, in cars, or in shelters with their families; and some have stable housing but often go hungry. They are a heterogeneous group made up of all races and ethnicities. However, students of color are overrepresented in the population of students in kindergarten through grade level twelve living below the poverty line (US Department of Education 2013, 30; Fuentes, O'Leary, and Barba 2013). For students you suspect are homeless or in a transitional living situation, work with school support staff (such as school counselors, school nurses, and school social workers), community partners (such as school-based health centers), or administrators to connect students and families with the McKinney-Vento Homeless Assistance Act lead for your district.

Homelessness Through Natural Disaster

Some of our students can experience homelessness and other traumas through natural disasters such as fires, mudslides, and floods. Natural disasters can be traumatic for students, as they experience the devastation of a familiar environment (ranging from their homes or schools to an entire community). School personnel can help students cope with the aftermath by remaining calm and assuring students they will be all right. Response efforts should focus on teaching students effective coping strategies, connecting with their friends and peer support, emphasizing their resiliency, allowing time for students to discuss their experiences, and securing mental health supports.

Source: *National Center for Homeless Education (n.d.).*

Individuals living in poverty face complex challenges. The resources of agencies working in collaboration, including the public education system, are required to mitigate the negative effects of poverty. Poverty is a risk factor for poor academic outcomes. Children and youth living in poverty are more likely than their peers to experience academic difficulty. However, the effects poverty has on individuals vary based on "… the individual's characteristics (such as personality traits including how one copes with trauma), specific life experience (such as loss of housing), and contextual factors (such as neighborhood crime), as well as the stressor's timing …" and the presence of protective factors, which includes affirming, positive, and supportive relationships with teachers and schools (Moore 2013, 4). Thus, the respectful, positive, and supportive schools called for throughout this chapter and the entire framework are especially crucial for students living in the psychologically and physically stressful circumstances that can come with poverty.

Children and youth living in poverty often miss many days of school; some stop attending altogether. Many transfer from one school to another as their living circumstances dictate. As a result, there are often gaps in their education. The health education standards and this framework are built on continuity of learning progressions across grade levels and grade spans. This presents both opportunities and challenges to students who are highly mobile or transient. On one hand, the standards may help these students by providing them with consistent health education standards among districts and schools. On the other hand, this assumption may impede the ability of some students who are new to the school, district, state, or country (such as new immigrant or migrant students) and reveal some gaps in their understanding and skills development. Additional supports, such as computer modules, home study, and independent studies, should be considered as alternative instructional tools.

When addressing the learning needs of children and youth living in poverty, it is important to recognize that students' backgrounds vary widely and that pervasive stereotypes and misconceptions about the poor can have damaging effects on students. Stereotypes and misconceptions can undermine the establishment of respectful and inclusive learning environments where all students can thrive both academically and socioemotionally. Gorski suggests that educators reject these myths and question their validity:

> The "culture of poverty" myth—the idea that poor people share more or less monolithic and predictable beliefs, values, and behaviors—distracts

> us from a dangerous culture that does exist—the culture of classism. … The most destructive tool of the culture of classism is deficit theory. In education, we often talk about the deficit perspective—defining students by their weaknesses rather than their strengths. Deficit theory takes this attitude a step further, suggesting that poor people are poor because of their own moral and intellectual deficiencies (Gorski 2008).

As Gorski emphasizes, myths that blame the poor for the inequities that exist in schools are not supported by evidence. Students living in poverty are capable learners who are fully able to engage and achieve in intellectually rich health education. Rather than approaching socioeconomically disadvantaged students and their families as having "deficits" that need to be "fixed," this framework takes an asset-based approach that views all students and their families having rich cultural experiences worth valuing.

Poverty and Classroom Engagement: Issues and Classroom Actions

Topic	Issue	Action
Health and Nutrition	Students living in poverty generally are in poorer health and have poorer nutrition than their more affluent peers. Poor health and nutrition affect attention, cognition, and behavior.	Ensure students have daily opportunities for physical activity and that they and their families are aware of free and reduced lunch programs, bus tokens, and medical (including mental health) services offered in the community.
Environmental Health	Students living in poverty may experience environmental injustices, which affect their mental and physical well-being. These include lack of access to clean water and exposure to air pollution and contaminated soil.	Help students recognize the environmental factors that affect their physical well-being and the health of their communities. Provide opportunities for "place-based" learning, and for students to empower themselves with knowledge and take action regarding local environmental injustices.

Topic	Issue	Action
Academic, Medical, and Science Language	Students living in poverty may have limited experience with the disciplinary language and vocabulary utilized in health education—academic, medical, and science language—than their more affluent peers.	Attend to academic language development in all areas of the curriculum and in classroom routines, with a particular emphasis on extended academic discourse as a bridge to academic writing. Academic, medical, and science language, which includes discipline-specific vocabulary, is a crucial component of programs and disciplinary learning (as well as all aspects of life, including learning health behaviors and skills). Provide ample time for extended collaborative discussions about academic topics, rich language models, tools to support academic discourse, discussing and analyzing how language works in academic texts, and daily opportunities for authentic and meaningful writing.
Effort	Some students living in poverty may appear to lack effort at school. This might be due to stress, hopelessness, or lack of resources to participate and complete classroom assignments. They may also have little time outside of school to complete classwork or study.	Recognize the critical role that teachers and schools play in students' willingness to exert themselves academically. Strengthen relationships between the school and students. Collaborate with your school social worker or administrators to obtain McKinney-Vento Homeless Act status or other district services and outside resources.

Topic	Issue	Action
Hope and the Growth Mindset	Low socioeconomic status may cause students to have a pessimistic outlook on the future, a feeling of powerlessness, or a feeling of being overwhelmed with daily constraints.	Ensure that students know that their futures and their abilities are not fixed. Provide high-quality feedback that is task-specific and actionable. Support students' beliefs in their potential (not their limitations) and the rewards of effort. At the same time, recognize and do not minimize the historical and contextual variables, such as institutionalized racism, that have led to income inequality. Support students to understand that poverty is a societal issue with individual repercussions. Find ways for students to become active in broader solutions, as well as individual ones.
Cognition	Some students living in poverty experience environmental trauma, which may affect cognition. Students living in poverty generally demonstrate lower academic achievement than their middle-class peers. They may have school attendance gaps or be preoccupied while in class. This may result in a need to assess for learning needs.	Understand the causes of potential cognitive and academic performance challenges. Solutions may involve providing more time for deeper learning or breaking content into smaller, more manageable components. Providing culturally relevant texts and topics may also support students to overcome challenges. Ensure that all students receive a rich, engaging, and intellectually stimulating curriculum. Encourage students and provide positive feedback.

Topic	Issue	Action
Relationships	Students living in poverty may face considerable adversity in forming healthy relationships with safe adults, such as teachers. Other students living in poverty may live in homes where there are very strong familial bonds and healthy relationships.	Ensure that adults at school are positive, caring, and respectful in all relationships with students and their families. Orient assets toward students and their families to recognize that students' relationships skills may be strong and to avoid stereotyping, and do not tolerate deficit language or deficit thinking. Make expectations clear. Above all, treat students living in poverty, as well as their families, with dignity. Convey the attitude that all students are welcome and capable of achieving to the highest levels. Be patient, as some students may seek to get their needs met in counterproductive ways. Be explicit in your classroom expectations. Implement positive behavioral interventions and supports.

Topic	Issue	Action
Distress	Students living in poverty often live in acute chronic distress, which impacts brain development, academic success, and social competence. This distress may be caused by increased levels of unemployment, violence in the community, or the constant specter of racism. They may demonstrate hypervigilance or behavior not expected or acceptable for a school environment.	Get to know the home and community environment in which students live to accurately identify the potential stressors that can lead to negative academic and social behavior. Build positive, caring, and respectful relationships. Teach coping skills. Seek advice from other school or district professionals, when appropriate. Teach and reinforce expected behaviors and do not assume prior knowledge.

Sources: *Adapted from Jensen (2013); Konkel (2012); and the California Department of Education's* English Language Arts/English Language Development Framework for California Public Schools *(2015).*

Students Who Are Living in Foster Care

More than 43,000—or about 1 in 150 students in California's K–12 public schools—spent some period of time in foster care during the 2009–2010 school year (Barrat and Berliner 2013, 6). Students in foster care—a group that is distinct from, but may overlap with, students living in poverty—lag significantly in academic preparedness compared to their peers who are not in foster care. Foster children are often especially resilient and share in many of the same academic strengths as other students. However, children and youth in foster care are more likely than other students to change schools during the school year, have a visible or nonvisible disability, and experience a greater academic achievement gap than students living in poverty (California Statewide Taskforce on Special Education 2015; Barrat and Berliner 2013). In addition, students in

foster care have the highest dropout rates and lowest graduation rates (Barrat and Berliner 2013, 36).

Compared to children who have not been in foster care, foster youth are at a significantly higher risk of mental and physical health issues, including learning disabilities, developmental delays, depression, anxiety, teen pregnancy and early parenting, sexually transmitted infections (STIs), behavior and speech issues, obesity, and asthma (Turney and Wildeman 2016). Foster youth are also one of the most vulnerable populations for sex trafficking and other forms of abuse. Case managers working with youth in foster care have a requirement to verify that the youth have received education that is compliant with the California Healthy Youth Act. This may require teachers, district staff, school support staff (such as school counselors, school nurses, and school social workers), and community partners (such as school-based health centers) to coordinate communication with case managers to make sure a student is not missing out on critical course content, and some instances may require a community of providers to supplement education to meet this need.

The achievement gap that foster children and youth experience has been referred to as an "invisible" one. Educators may not be aware that their students are foster children or youth, and they may be unfamiliar with learning needs and appropriate support services that are particular to these students' life circumstances. However, foster children and youth are more likely to thrive in school when districts and teachers know who their foster children and youth are, place foster children strategically in the most appropriate schools and classrooms, and educate themselves about how to provide effective, motivating, engaging, and relevant instruction and support services. Additionally, educators can refer students to participate in expanded learning opportunities, which provide collaborative, high-quality learning, available at the school site.

One example of support for school leaders is the College and Career Pathways project, which provides guidance to high schools on how to help foster youth plan for college and careers. Another resource is the California Department of Education Foster Youth Services web page, which provides numerous resources related to foster youth services and programs. Ask school support staff (such as school administrators, school counselors, school nurses, and school social workers) or community partners (such as school-based health centers) about connecting students to the district foster youth liaison to obtain additional learning resources and health services for students.

Students Who Are Gifted and Talented (GATE) Learners

For purposes of this framework, advanced learners and gifted learners are students who demonstrate or are capable of demonstrating performance in health education at a level significantly above the performance of their age group. In California, each school district sets its own criteria for identifying gifted and talented students.

The informal identification of students' learning needs is important because some students, particularly California's culturally and linguistically diverse learners, may not exhibit advanced learning characteristics in culturally or linguistically congruent or familiar ways. For example, a kindergartner who enters United States schools as a newcomer to English and is fluently translating for others by the end of the year may not be formally identified as advanced but may in fact be best served by programs offered to gifted and talented students. Likewise, some teachers or school support staff may fail to identify students with visible and nonvisible disabilities as gifted and talented. These students are sometimes referred to as "twice exceptional" and instruction needs to address both sets of needs (International Dyslexia Association 2013; Nicpon et al. 2011). Teachers should be prepared through pre-service and in-service professional learning programs to recognize the range of learners who are gifted and talented. As noted previously, the populations discussed in this chapter are not mutually exclusive.

A synthesis of research on the education of students identified as gifted and talented suggests they should be provided the following (Rogers 2007):

- Daily challenges in their specific areas of talent
- Regular opportunities to be unique and to work independently in their areas of passion and talent
- Various forms of subject-based and grade-level-based acceleration as their educational needs require
- Opportunities to socialize and learn with peers with similar abilities
- Instruction that is differentiated in pace, amount of review and practice, and organization of content presentation

Instruction for advanced learners and gifted learners should focus on adding depth and complexity to their understanding of the topics being studied, not necessarily in adding new topic areas or skipping courses or content. For example, providing students the following opportunities can be especially valuable for advanced learners and gifted learners:

- Engaging with appropriately challenging text and content
- Conducting research
- Engaging in independent or small group projects and health-related service learning
- Using technology creatively
- Writing regularly on topics that interest them

These experiences allow students to engage more deeply with content and may contribute to motivation. Instruction that focuses on depth and complexity ensures cohesion in learning rather than piecemeal "enrichment."

Students Who Identify as Lesbian, Gay, Bisexual, Transgender, or Questioning

All California's children and adolescents have the fundamental right to be respected and feel safe in their school environment, yet many students do not feel supported in expressing their gender, gender identity, gender expression, and sexual orientation. California *EC* Section 210.7 defines gender as sex and includes a person's gender identity and gender expression. *Gender identity* refers to the gender with which a person identifies and may not necessarily match an individual's sex assigned at birth. *Gender expression* refers to a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's assigned sex at birth. *Sexual orientation* refers to a person's enduring pattern of romantic and sexual attraction to persons of the opposite sex or gender, the same sex or gender, or to both sexes or more than one gender.

There are an infinite number of ways an individual may identify or choose to express their individuality and sense of self. This list is also expansive as it relates

to gender, and students may not conform within social norms of the binary gender identities of male and female (e.g., gender nonbinary, gender nonconforming, androgynous, gender queer, or gender fluid). It is important to remember a person's gender and sexuality *identity* do not necessarily correlate with their *activity*, and educational approaches need to be identity-sensitive but behavior-focused, insomuch as a primary goal of health education is to positively influence the health behavior of individuals and communities as well as the living and working conditions that influence health (Society for Public Health Education n.d.). That is, if a male does not identify as gay or bi, but still has sex with other men, then discussions that are only about "gay" sex, for example, can miss important aspects of actual human behaviors.

The usage of LGBTQ+ throughout this document is intended to represent an inclusive and ever-changing spectrum and understanding of identities. Historically, the acronym included lesbian, gay, bisexual, and transgender, but has continued to expand to include queer, questioning, intersex, asexual, allies, and alternative identities (LGBTQQIAA), as well as expanding concepts that may fall under this umbrella term in the future.

Because some identities may hold a negative stigma for some students, it may prevent them from receiving important information or content. Be mindful of students' identified gender pronouns and affirmatively acknowledge the existence of relationships that are not heterosexual by actively using examples in class discussions and activities. Use gender-neutral language when referencing gender identity or sexual orientation to create an inclusive and safe environment. It is important to not make assumptions about how a student identifies based on appearance and to be as culturally sensitive and inclusive as possible when discussing gender and relationships. Teachers should generally avoid dividing the class by gender, having single-gender teams or activities, and should try to mix traditional gender roles in class activities, such as role playing.

Educators should be mindful of students who are not public about their gender identity or sexual orientation and ensure gender identity or sexual orientation is never revealed or discussed with anyone without the student's explicit consent. This is especially true when educators communicate with other students, families, and other educators. Research indicates that students who are gender nonconforming are less likely than other students to feel very safe at school and

more likely to indicate that they sometimes do not want to go to school because they feel unsafe or afraid (Kosciw et al. 2018). Furthermore, they are more likely to be teased and bullied about their gender expression (Kosciw et al. 2018). Specific to California, the majority of LGBTQ+ students (up to 63 percent) have been victimized at school based on their sexual orientation, gender, or gender expression by either verbal or physical harassment or physical assault (GLSEN 2017). Additionally, LGBTQ+ students report feeling unsafe and experiencing harassment or assault at school (GLSEN 2017). They often miss days of school to avoid a hostile climate.

All California educators have a duty to protect students' right to obtain an education in a safe and welcoming environment and their right to physical and psychological safety. They also have a duty to ensure that each of their students has the opportunity to thrive. The California *EC* sections 200 et seq. prohibit discrimination on the basis of various protected groups, including sexual orientation, gender, gender identity, and gender expression. California recognizes that discrimination and harassment in schools "can have a profound and prolonged adverse effect on students' ability to benefit from public education and maximize their potential" (California Department of Education 2012). Furthermore, research suggests that victimization based on sexual orientation or gender expression is related to lower academic achievement and educational aspirations, as well as poorer psychological well-being and higher rates of suicide ideation. School-based supports may play a significant role in mitigating these risk factors (Kosciw et al. 2013).

General recommendations from GLSEN for schools regarding students in this diverse population include the following (2019):

- Adopt and implement clear and comprehensive anti-bullying policies and procedures thus promoting respectful and safe environments for all students
- Provide professional development to educators as accurate information and terminology evolves, and ensure that all students have access to a welcoming environment and supportive, respectful teachers and staff who will intervene on their behalf
- Provide a supportive environment for teachers to be out and explicitly support them via policies and practices
- Increase students' access to an inclusive curriculum with sensitivity to pronouns

- Work with your school teacher librarian and media specialist to ensure students have access to inclusive and diverse reading and media materials

Additional recommendations from GLSEN (2019) include the following:

- Make available and share age-appropriate instructional materials and resources that reflect the diversity of humankind and thoughtfully deal with the complexities and dynamics of intolerance and discrimination
- Teach students by example and through discussion how to treat everyone with dignity and respect
- Ensure the classroom environment is inclusive by using posters or images that depict students and people of all abilities—consider hanging a small rainbow pride flag or *safe zone* sticker that signifies that all gender identities and expressions are welcome in the classroom; also, partner with school administration to ensure that this inclusive environment is consistent throughout the entire school campus
- Encourage the formation and continuation of LGBTQ+ student groups, such as Genders and Sexualities Alliance Network (GSA), which improve the school environment and inclusive climate
- Consider seeking professional development opportunities in LGBTQ+ issues
- Teachers, administrators, and staff should be informed that they are protected from workplace discrimination and harassment according to the California Fair Employment and Housing Act (see *Government Code* sections 12900–12996)

California students who are not themselves in this population may have parents, guardians, family, or friends who are lesbian, gay, bisexual, transgender, queer, or questioning. All students and their families need to feel safe, respected, and welcomed in school. The health education standards related to growth, development, and sexual health encompass a broad scope of concepts and skills, including acquiring information about interpersonal relationships and gender roles. Many standards in this area cover aspects of healthy relationships and inclusivity, and recognize that there are individual differences in growth and development, physical appearance, gender roles, gender expression, and sexual orientation.

Transgender students often experience additional difficulties in school beyond bullying and harassment. In some cases, their gender identity is not recognized and respected. It is important the school community understands and supports

transgender students' right to be addressed by the correct name and pronouns and access facilities and programs consistent with their gender identity, in addition to avoiding language and teaching that is exclusionary of transgender students. The same is true of students who identify as nonbinary, meaning their gender is neither strictly male nor female. California *EC* Section 221.5(f) specifies that students in California have the right to participate in school activities, including sports, and use facilities consistent with their gender identity, irrespective of the gender listed on their records.

The example below provides some tangible ideas for ensuring that instructional materials and resources that both reflect and honor the diversity of humankind and thoughtfully deal with the complexities and dynamics of intolerance and discrimination.

SNAPSHOT

Learning from Diverse Role Models in High School

The teachers at the Helen Rodriguez-Trías Health Professions High School work together to ensure that their students learn about role models in health professions, inspiring their students to persevere in academic coursework and pursue careers in health fields. The role models the teachers select reflect the cultural, ethnic, gender, gender identity, sexual orientation, and other aspects of diversity of students in the school. One of the role models students learn about is teen scientist Jack Andraka. When he was a high school student, he invented an inexpensive early detection test for pancreatic, ovarian, and lung cancers, and has won numerous awards for his scientific work. In addition to learning about Andraka's contributions to health sciences, they also learn how the young inventor and scientist, openly gay since the age of thirteen, has earned international praise for sharing his personal and motivational story—in multiple documentaries, journal articles, and a memoir—depicting his experiences of bullying, depression, rejection, and ultimately international success.

One of the texts students read and discuss is an op-ed Andraka wrote for *Advocate*, titled, "How Gay Genius Alan Turing Got Me Through Middle School" (2014). In the piece, Andraka explains how inspiring and motivational it was for him in middle school to discover a role model who was also gay: Alan

Turing. Andraka laments the paucity of role models for LGBTQ+ youth and advocates for changes in schools. As the students learn about Andraka, they discuss his contributions to health science and how he serves as a role model for other teens. In an activity that connects health education and science instruction, small groups select one of the "do-it-yourself" science experiments included in each chapter of Andraka's memoir and work together to conduct them. These activities should be jointly developed by health education and science teachers.

Students also learn about the work of Nadine Burke Harris, a pediatrician and California's first Surgeon General, through a TED Talk in which she explains the public health crisis of childhood trauma and how it affects people across their lifetimes (2014). The students discuss the key points from the talk, including how adverse childhood experiences have real, tangible effects on the development of the brain and on lifelong mental and physical health. They learn that, in addition to affecting their mental well-being, people who grew up with a family member who suffered from substance abuse or mental illness, were neglected, or experienced other high levels of early adversity are at triple the risk for heart disease and lung cancer. Harris explains how health professionals and the community at large can use the knowledge gained from science for the prevention and treatment of trauma to reduce the effects of adversity and treat children and youth through holistic services and education, such as her work at the Center for Youth Wellness in San Francisco. Through their animated discussions of the TED Talk and a group research project they conduct on the topic, the students create public service announcements to educate their local community, focusing on evidence-based solutions.

Another group of role models students learn about are people who came to California as undocumented immigrants and later entered the health professions. For example, they read *Becoming Dr. Q: My Journey from Migrant Farm Worker to Brain Surgeon*, the memoir of Dr. Alfredo Quiñones-Hinojosa, also known as "Dr. Q," who grew up in an impoverished Mexican village; journeyed to California at the age of fourteen; worked as a migrant farmworker and a welder in the San Joaquin Valley; earned a bachelor's degree at the University of California, Berkeley; attended Harvard Medical School (earning his citizenship while a student); and established himself as a successful neurosurgeon (2011). In a TEDx Talk, Quinones-Hinojosa speaks of how proud he is to be a Mexican and an American, living the American dream, and using his transformed life to save the lives of others.

Students read a book by and view videos about Temple Grandin, a prominent author and speaker on autism and animal rights. Diagnosed with autism as a child, Grandin personifies the importance of people on the autism spectrum—who can think in unique ways—contributing to the world and can think in unique ways. Students learn about the autism spectrum, how it spans from people who are famous scientists to those who are challenged to care for their daily needs, and how educators, family members, and the community at large can be more inclusive and supportive of people with autism. They also learn about the significant impact Grandin's work has had on animal welfare, including how her work designing humane handling systems for half the cattle-processing facilities in the United States. They discover how Grandin's books and speeches about her life as a person with autism have increased and shaped the world's understanding about autism and given voice to others with the condition.

Other inspirational leaders to consider include Michael J. Fox and Stephen Hawking, given their respective contributions to research and publications in health and science.

In addition to learning about specific role models, students conduct their own research in collaborative groups to investigate people in health professions they are interested in, such as diverse leading thinkers in alternative medicine and nutrition, environmental justice, or mental health. They showcase their research in a community event at city hall and post their multimedia presentations on a website dedicated to promoting diversity in the health professions.

Students with Visible and Nonvisible Disabilities

Approximately ten percent of Californians have a visible or nonvisible disability (Cornell University 2016). In accordance with the Individuals with Disabilities Education Act (also known as the IDEA), California local education agencies provide special education and other related services as a part of a guaranteed free appropriate public education to students who meet the criteria under one of the following categories (presented alphabetically; see the National Dissemination Center for Children with Disabilities for detailed descriptions):

- Autism
- Deafness
- Deaf-blindness
- Emotional disturbance
- Hearing impairment
- Intellectual disability
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment, including blindness

Students with specific learning disabilities and speech and language impairment make up approximately more than half of students receiving special education services (National Center for Education Statistics 2019). While specific learning disabilities vary widely, difficulty with reading is the most common type of specific learning disability. However, it is important to note that students experiencing difficulty while reading do not necessarily have a learning disability. There are many causes for low achievement in reading, including inadequate instruction and lack of access to materials. Under the IDEA, a student who is performing below

grade level may not be determined to have a specific learning disability if the student's performance is primarily a result of limited English proficiency or a lack of appropriate instruction.

A student in a particular disability category only represents a label for a qualifying condition for special education purposes. The spectrum of disability and educational needs within each disability category varies widely. Thus, each individual education program should be based on a student's individual needs—not their label. Students who receive special education and related services in the public school system must have an Individualized Education Program (also known as an IEP). The Individualized Education Program is a federally mandated individualized document specifically designed to address an individual's unique educational needs. It serves as the foundation for ensuring a quality education for each student with a disability. To learn more about Individualized Education Programs, accommodations, modifications, and resources designed to support the needs of students with visible and nonvisible disabilities, collaborate with the school's special education teachers and providers of student services.

Accommodations and Modifications for Students with Visible and Nonvisible Disabilities

Accommodations play important roles in helping students with visible and nonvisible disabilities access the core curriculum and demonstrate what they know and can do. The student's Individualized Education Program team determines the appropriate accommodations for both instruction and assessments. Decisions about accommodations are made on an individual student basis, not on the basis of category of disability. Many students who are eligible for special education services are able to achieve standards when the three following conditions are met:

1. Standards are implemented within the foundational principles of Universal Design for Learning (UDL) and Positive Behavioral Support (see resources such as Center for Applied Special Technology [CAST], the California Department of Education's Positive Behavioral Support web page, and other UDL resources).

2. Evidence-based instructional strategies are implemented and instructional materials and curriculum reflect the interests, preferences, and readiness of each student to maximize learning potential.
3. Appropriate accommodations are provided to help each and every student access grade-level content and complete tasks successfully.

The Clearinghouse for Specialized Media and Technology provides accessible instructional materials in Braille, Large Print, and Audio formats in accordance with *EC* Section 60313. These resources intended to support students with visual impairment or other disabilities in grade levels K–8 who are unable to progress with conventional print materials. Materials are available to all public schools in California at no cost. Member registration is required, and any public school employee may register. Information and registration are available at the California Department of Education's Clearinghouse for Specialized Media and Technology web page.

Modifications to curriculum for students with visible and nonvisible disabilities are unique and are based on the student's Individualized Education Program. All decisions about modifications to curriculum to meet the needs of a student should be made by the student's IEP team and should align to the IEP goals based on appropriate grade-level standards. Additional information and resources can be found by visiting the California Department of Education Special Education Division Services and Resources web page.

Students with visual and nonvisual disabilities may experience higher rates of sexual abuse and assault (Rape Abuse and Incest National Network 2020). When providing sexual health education to students with developmental disabilities, it is important to make accommodations, perhaps in partnership with their special education teachers, to ensure they receive developmentally appropriate sexual health instruction. For example, some students with visible or nonvisible disabilities may require multiple opportunities to practice the concrete skills needed to affirmatively give consent, set a boundary, and tell a trusted adult when a boundary has been crossed. For more information and resources, see "Sexual Health Education for Young People with Disabilities, Research and Resources for Educators" (Advocates for Youth 2016).

Establishing an Inclusive Health Education Classroom through UDL

Principle I

Provide multiple means of engagement to tap individual learners' interests, challenge them appropriately, and motivate them to learn.

UDL Guidelines	Health Education Classroom Examples
Guideline 7: Provide options for recruiting interest.	▪ Optimize individual choice and autonomy by providing learners choice in topics or the order in which they accomplish tasks. ▪ Leverage students' cultural backgrounds, as well as youth culture, to promote culturally relevant health learning. ▪ Provide home and community audiences for students' work. Connect with the community via field trips or a guest speaker program to learn about health. Regularly check in with parents, guardians, and caretakers on how their child is performing.
Guideline 8: Provide options for sustaining effort and persistence.	▪ Minimize distractions and promote focus. For example, use norms to ensure respectful interactions, and provide quiet spaces where students can refocus when needed. ▪ Vary demands and resources to optimize challenge. For example, provide a range of resources appropriate for and of interest to a range of learners. ▪ Foster collaboration and communication by offering structures for group work and clearly discussing expectations. ▪ Increase mastery-oriented feedback by providing timely and specific feedback and focusing on learning, growth, and a growth mindset.

UDL Guidelines	Health Education Classroom Examples
Guideline 9: Provide options for self-regulation.	▪ Promote high expectations and belief in students. For example, encourage students by helping them to set personal goals and supporting them to achieve them. ▪ Facilitate personal coping skills and strategies. For example, provide or co-construct with students' checklists for managing behavior. ▪ Support students to develop self-awareness, assess their progress toward personal to goals, and to reflect on growth or how to improve.

Principle II

Provide multiple means of representation to give students various ways of acquiring, processing, and integrating information and knowledge.

UDL Guidelines	Health Education Classroom Examples
Guideline 1: Provide options for perception.	▪ Provide large print or graphic representations of health models, such as decision-making and goal-setting models. ▪ Provide written transcripts, provide braille texts, or use American Sign Language. ▪ Provide descriptions of images, tactile graphics, or physical objects.

UDL Guidelines	Health Education Classroom Examples
Guideline 2: Provide options for language, mathematical expressions, and symbols.	▪ Provide glossaries and bilingual dictionaries for accurate health education terms. ▪ Use digital text with accompanying human voice recording of health-related articles. ▪ Use students' primary language. ▪ Provide illustrations, photos, simulations, or interactive graphics. For example, when teaching ATOD content, a photo that clearly shows that 12 ounces of beer, 5 ounces of wine, and 1.5 ounces of distilled spirits or hard liquor are all equivalent to one serving of alcohol. ▪ Make explicit the connections between text and illustrations, diagrams, or other representations of information.
Guideline 3: Provide options for comprehension.	▪ Activate or supply background knowledge (e.g., use advanced organizers and make explicit cross-curricular connections). ▪ Highlight patterns, critical features, big ideas, and relationships. For example, use outlines to emphasize important health concepts or to draw students' attention to critical features. ▪ Guide information processing, visualization, and manipulation. For example, provide explicit prompts for each step in a sequential process, such as a research task or role-playing a situation. ▪ Maximize transfer and generalization (e.g., embed new ideas in familiar contexts).

Principle III

Provide multiple means of action and expression to provide students with options for navigating and demonstrating learning.

UDL Guidelines	Health Education Classroom Examples
Guideline 4: Provide options for physical action.	Vary the methods for response and navigation. For example, have students respond to review questions in a game-like fashion using whiteboards or survey clickers. Integrate assistive technologies. For example, have touch screens and alternative keyboards accessible for projects.
Guideline 5: Provide multiple tools for construction and composition.	Use multiple media for communication. For example, have students demonstrate their health education learning through film or multimedia. Have students use role playing and dramatizations to practice health behavior skills. Provide concept mapping tools to support solving problems regarding health education topics. Use multiple types of assessment methods, such as the use of portfolios or interviews, to ensure students' knowledge and skills are accurately assessed.
Guideline 6: Provide options for executive functions.	Guide appropriate goal setting. For example, support learners to set health education goals and ways of measuring progress toward the goal. Support learners to plan for and engage in individual and group tasks. For example, identify priorities and a sequence of steps for completing the tasks. Set aside time for students to generate and ask questions at the end of each health class. Students can also submit anonymous questions via a Q&A box kept in the classroom with responses delivered at the beginning of each class period. Provide success criteria for assignments, prompt learners to identify the type of feedback they seek, and provide them with protocols to provide peer feedback.

When initial instruction is planned in such a way that it flexibly addresses learner variability, more students are likely to succeed. Fewer students will find the initial instruction inaccessible and therefore fewer will require additional, alternative "catch-up" instruction. By taking the time to really get to know their students with disabilities and remaining open to listening, learning, and responding with genuineness and empathy, teachers can draw students together as a learning community.

Sources: *Select content adapted and expanded from the California Department of Education (2015, chapter nine), Pateman et al. (2001), Telljohann et al. (2015), and CAST (2018).*

Students Who Have Experienced Trauma

It is important to note that many students have experienced some form of traumatic event, including the loss, deportation, or incarceration of a family member, or any form of abuse or bullying. These students, while not always easily identified, often need additional support to achieve educational goals. Before introducing topics that are likely to trigger responses in students who have experienced trauma, teachers should inform school support staff and administrators so they are prepared to provide support and interventions to students and address concerns raised by students or parents, guardians, and caregivers. School staff should be mindful of a delicate balance between sharing information to keep a student safe and maintaining a student's confidentiality.

Students who have experienced trauma may have a number of varying trauma responses, which can impact both mental and physical health and may include the following:

- Falling behind in assignments
- Being tardy or truant
- Displaying problem behaviors that can be misdiagnosed as a symptom of something other than their trauma experience
- Appearing distracted
- Having difficulty concentrating
- Exhibiting displaced anger or aggression
- Displaying symptoms of depression and anxiety

Health education teachers, teachers, administration, staff, peer health educators, or health educators from community agencies may be in a position to suggest helpful resources and connect students to school supports including the school nurse, social worker, or counselor. Additionally, teachers may also be able to refer students to community-based organizations that can offer additional support. If a student discloses abuse or there is reason to suspect child abuse, follow mandated reporting laws and school policies immediately (see the Mandated Reporting section for mandated reporting requirements in the "Introduction" chapter). An Individualized Education Program may be necessary to support learning and any special needs. To further support students, districts should provide professional development on understanding trauma and implementing trauma-informed educational approaches. Understanding trauma and having systems in place to support the student as an individual can also establish a school climate that promotes health and safety for all.

Multi-Tiered System of Supports

Since health education includes both the physical and mental health of our students, it is important for health educators to understand the connection between the academic and social–emotional learning supports within the structure of the Multi-Tiered System of Support (also known as MTSS) utilized in a local education agency. A coordinated system of institutionalized supports and services is crucial for ensuring appropriate and timely attention to students' needs such as those experiencing mental health issues. The Multi-Tiered System of Supports is a multifaceted approach that aligns academic, behavioral, and social–emotional learning in a fully integrated system of support for the benefit of all students. The Multi-Tiered System of Supports is a framework for aligning resources and initiatives, which could include systems such as UDL, Response to Instruction and Intervention (also known as RtI^2), and Positive Behavioral Interventions and Supports (also known as PBIS).

Each local education agency should have a way of organizing supports so that both the academic side and the social–emotional learning side are aligned to serve the whole child (California Department of Education 2017). Research has shown that problems in one area (academic or social–emotional) can predict future problems in other areas (McIntosh et al. 2008). Since health education includes both the physical and mental health of our students, it is important for health educators to

understand the connection between the academic and social–emotional learning supports within the structure of the Multi-Tiered System of Supports utilized in a local education agency.

Academic and social–emotional supports should be combined and consider shared outcomes. For local education agencies, this may mean integrating or braiding initiatives into existing programs and priorities. This integration includes identifying how all initiatives, parallel systems, data, and practices within a school can be unified to create a common focus for staff. One example is to combine the academic support team with the behavioral support team at a school site. By combining both support teams, the new, larger team is able to review data, systems, and practices from the whole-child perspective and coordinate services accordingly (McIntosh, Horner, and Sugai 2009).

Within Multi-Tiered System of Supports are tiered levels of prevention: primary, secondary, and tertiary. The primary tier (Tier 1) of prevention is universal and intended to address the needs of all students. For social–emotional learning this would include an emphasis on having a schoolwide mental, emotional, and social health program. The secondary tier (Tier 2) of prevention is intended for small groups of students who are not responsive to the primary preventions. Tier 2 could include supplemental social behavior support and/or coordinated mental health services. Tertiary prevention (Tier 3) is individualized and intensive for those students unresponsive to Tier 1 and 2 preventions over a period of time. Tier 3 prevention is informed by a specialized team of special educators, behavioral interventionists, school psychologists, and school counselors, and school social workers. The Multi-Tiered System of Supports team determines which students need this level of support. All health educators and administrators are encouraged to play an integral role and collaborate with the specialized team to advocate and represent the student's health education needs.

Culturally Responsive PBIS Implementation

Current recommendations in the Positive Behavioral Interventions and Supports (PBIS) literature for considering cultural and contextual factors in culturally responsive PBIS implementation focus on three areas of practice: (1) collaborating with families and community members in teaching and reinforcing schoolwide behavioral expectations, (2) monitoring disproportionality in office discipline referrals between dominant and nondominant groups through analysis of trends in data disaggregated across student demographic characteristics (e.g., race/ethnicity), and (3) providing professional development aimed at increasing practitioners' awareness of differences between their own and nondominant students' cultural patterns of communication styles, roles of authority, etc. that will allow them to interpret individual students' problem behaviors correctly. All health educators, school support staff (such as school counselors, school nurses, and school social workers), community partners, school-based health centers, and administrators are encouraged to play an integral role and collaborate with the specialized team to advocate and represent the student's health education needs.

Source: *Bal, Thorius, and Kozleski (2012).*

Ensuring access to, and equity in, quality health education is a shared responsibility—one that begins with recognizing that each California student is an individual with multiple layers of identity, a range of interests and talents, and the basic human needs for connection, respect, and dignity. When health education teachers work collaboratively within schools and districts, with families, and with a variety of community organizations to create welcoming, safe, affirming, caring, respectful, and engaging learning environments, they can ensure that all students have the opportunity to thrive academically and achieve their full potential.

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