

Suicide Prevention Program Community Advisory Board

Membership Application

The Community Advisory Board (CAB) is an advisory body to the Suicide Prevention Program (SPP) within the Division of Violence and Injury Prevention at the Massachusetts Department of Public Health.

CAB Background:

People who receive Massachusetts Department of Public Health (MDPH) Suicide Prevention Program funded services are essential to the development of SPP programs and services. The SPP currently does not have a formal mechanism to receive feedback about our funded services from people who receive those services. The MDPH Bureau of Substance Abuse Services and the MDPH Office of HIV/AIDS operate long-standing, successful Community Advisory Boards, which have positively informed their programs and services to better serve their clients and guide their work in a more client and community-centered way.

CAB Mission

The mission of the Suicide Prevention Program Community Advisory Board (CAB) is to provide a mechanism for community members who receive SPP funded services (hereafter referred to as stakeholders) to have meaningful input into the development of services, programs, and policies that address their needs. The CAB seeks to support the creation of comprehensive, community-based suicide prevention, intervention, and support services that are accessible, inclusive, responsive, and of high quality, and one that supports the adage, "Nothing about us without us."

CAB Goals

As service users, stakeholders are well positioned to assess the quality, appropriateness, and effectiveness of funded services. In the pursuit of this mission, the CAB has the following goals:

- To provide stakeholder input to the development and implementation of Massachusetts Department of Public Health (MDPH) Suicide Prevention Program services, policies, and community-based providers.
- To act as liaison between stakeholders, the MDPH SPP, and service providers.
- To educate and bring together stakeholders through a variety of activities that support health and well-being and encourage stakeholder involvement.
- To ensure equitable programs and services.

CAB Meetings

There will be a total of twelve meetings in fiscal year 2017. Meetings will be held monthly and take place from 6:00-8:00pm. We will ask that CAB members commit to participating in at least 7 out of 12 meetings either in person or by phone. The first meeting will be in the MetroWest area, and future meeting locations will be determined based on feasibility and accessibility for CAB members. Dinner will always be provided.

Reimbursements

CAB members may be reimbursed for parking while attending CAB meetings.

CAB Membership Application Process

If you would like to become a SPP CAB member, please fill out the application below and submit to Carey Howard by no later than August 1st, 2016. You may email, mail, or drop off your application as follows:

Email: Carey.Howard@state.ma.us
Mail or Drop Off: Carey Howard, Suicide Prevention Program
250 Washington Street, 4th Floor
Boston, MA 02108

Once all applications have been received and reviewed, staff members from the Suicide Prevention Program will reach out to all applicants within 1-2 weeks.

If you have any questions about the SPP CAB application process and/or serving on the CAB please contact Carey Howard at Carey.Howard@state.ma.us or Alison Brill at alison.brill@state.ma.us or 617-624-5299.

If you are interested but cannot commit to attending regular meetings you may still be able to participate in the CAB in another way. Please reach out to a Suicide Prevention Program staff member if you have questions/concerns about your involvement in the CAB.

Thank you. We look forward to receiving your application.

Massachusetts Suicide Prevention Program Community Advisory Board Application August 2016-August 2017

Please provide all of the information requested. Your information will only be available to Suicide Prevention Program staff. If there is a personal question that you feel uncomfortable answering or a question that is not applicable to you, please leave it blank.

First Name:

Last Name:

Address:

Email Address:

Primary Phone Number:

Secondary Phone Number:

SPP CAB members will regularly receive information to review prior to CAB meetings. Indicate which method would work best for you to receive such materials. ☐ Email ☐ Mail

Indicate which category you would be able to represent as a member of the SPP CAB.
Check all that apply

I am a/n a or have:

- ☐ Loss survivor (lost a loved one to suicide)
- ☐ Attempt survivor
- ☐ Friend or family member of an attempt survivor
- ☐ Currently receiving mental health services
- ☐ Received mental health services in the past
- ☐ Suicide prevention advocate/volunteer

☐ I am an individual who is not receiving suicide prevention services

☐ Other, please specify:

Please indicate the regions of Massachusetts in which you work, live, and/or receive Suicide Prevention Program related Services
Check all that apply.

I work in:	<input type="checkbox"/> Cape and Islands <input type="checkbox"/> Bristol County <input type="checkbox"/> Pioneer Valley	<input type="checkbox"/> Northeast MA <input type="checkbox"/> Central MA <input type="checkbox"/> Berkshire	<input type="checkbox"/> Greater Boston <input type="checkbox"/> Metro West <input type="checkbox"/> Plymouth
I live in:	<input type="checkbox"/> Cape and Islands <input type="checkbox"/> Bristol County <input type="checkbox"/> Pioneer Valley	<input type="checkbox"/> Northeast MA <input type="checkbox"/> Central MA <input type="checkbox"/> Berkshire	<input type="checkbox"/> Greater Boston <input type="checkbox"/> Metro West <input type="checkbox"/> Plymouth
I receive services in:	<input type="checkbox"/> Cape and Islands <input type="checkbox"/> Bristol County <input type="checkbox"/> Pioneer Valley	<input type="checkbox"/> Northeast MA <input type="checkbox"/> Central MA <input type="checkbox"/> Berkshire	<input type="checkbox"/> Greater Boston <input type="checkbox"/> Metro West <input type="checkbox"/> Plymouth

Please provide all of the information requested. Your information will only be available to SPP staff. If there is a personal question that you feel uncomfortable answering or a question that is not applicable to you, please leave it blank.

I am:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Other: _____
I identify as:	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Other: _____
My age range is:	<input type="checkbox"/> 45 – 49	<input type="checkbox"/> 18 – 29 <input type="checkbox"/> 50 – 59	<input type="checkbox"/> 30 – 39 <input type="checkbox"/> 60 – 69	<input type="checkbox"/> 40 – 44 <input type="checkbox"/> 70 or over
I am:	<input type="checkbox"/> Hispanic or Latino/a		<input type="checkbox"/> Not Hispanic or Latino/a	
I am: (select <u>at least</u> 1)	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native	

I speak in:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Other:
I read/write in:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Other:
I have the following accessibility needs:				

I am an employee, consultant, volunteer, or board member of the following organizations:	
<u>Organization</u>	<u>Role</u>

Please indicate which special skills, areas of expertise, or life experiences you would bring to the SPP CAB.

Check all that apply.

I have skills and experience with:	<input type="checkbox"/> Advocacy/Awareness Building <input type="checkbox"/> Community Organizing <input type="checkbox"/> Research and Evaluation <input type="checkbox"/> Epidemiology <input type="checkbox"/> Public Health Administration <input type="checkbox"/> Agency Administration <input type="checkbox"/> Health Communications/Marketing <input type="checkbox"/> Advisory/Planning Bodies <input type="checkbox"/> Legal/Financial Services <input type="checkbox"/> Faith-Based Communities	<input type="checkbox"/> Substance Use Services <input type="checkbox"/> Housing Services <input type="checkbox"/> Case Management Services <input type="checkbox"/> Holistic Health Services <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Individual Suicide Prevention Services <input type="checkbox"/> Group Suicide Prevention Services <input type="checkbox"/> Suicide Outreach/Field Work <input type="checkbox"/> Suicide Counseling & Screening Services
I have personal and/or professional expertise regarding these populations:	<input type="checkbox"/> Attempt Survivors <input type="checkbox"/> Veterans <input type="checkbox"/> Loss Survivors <input type="checkbox"/> Public Safety Personnel (EMS, Police, Fire, etc.) <input type="checkbox"/> People with Lived Experience with Substance Abuse <input type="checkbox"/> People with Lived experience with Mental Illness	<input type="checkbox"/> Middle-aged People <input type="checkbox"/> Young People <input type="checkbox"/> LGBTQ People <input type="checkbox"/> People Over age 55 <input type="checkbox"/> Immigrants/Refugees <input type="checkbox"/> Communities of Color <input type="checkbox"/> Inmates/Ex-Offenders <input type="checkbox"/> Trauma Survivors
Other expertise, skills, or experiences:		

Please respond briefly to the questions below.

1.	From the above list of skills, expertise, and life experiences, which do you find <u>most</u> important in shaping the perspective and advisory guidance you will share with the SPP CAB?

2.	Why would you like to be a SPP CAB member?

Statement of Applicant Commitment

If selected to serve as a member of the Suicide Prevention Program Community Advisory Board:

- ☐ Information shared during SPP CAB meetings will be documented and disseminated as meeting minutes. When possible, SPP CAB staff will seek to protect the anonymity of CAB members. However, in order to use the information generated during these CAB meetings will to inform future decisions about Suicide Prevention Services offered by the MA Department of Public Health, full anonymity cannot be maintained. In submitting this application I understand that my identity as a member of the SPP CAB will not be confidential and anonymous.
- ☐ I will devote sufficient time and energy to actively assist the SPP CAB in meeting the goals and the objectives set forth by the Department of Public Health, Suicide Prevention Program.

Therefore, if chosen as a member of the CAB I agree that:

- ☐ I will sit on the board for the full term of my application from August 2016-August 2017
- ☐ I will attend at least 7 out of 12 of the monthly CAB meetings during my yearlong term.
- ☐ I will provide advance notice to SPP CAB if I am unable to attend a meeting
- ☐ If I must be unexpectedly absent from a meeting listed above due to illness, family emergency, etc., I will inform SPP CAB staff with as much notice as possible.
- ☐ If conference calls or other SPP CAB activities are conducted, I will make every effort to participate.
- ☐ I cannot agree to all of the statements above.

Please explain:

Thank you. We look forward to receiving your application no later than August 1st, 2016.
If you would have questions about joining the SPP CAB or about the membership application process, please contact Carey Howard at Carey.Howard@state.ma.us, or call Alison Brill at 617-624-5299.

<u>Submit completed applications no later than August 1st, 2016 to:</u>	Email:	Carey.Howard@state.ma.us
	Mail or Drop Off:	Carey Howard, Suicide Prevention Program 250 Washington Street, 4 th Floor Boston, MA 02108