Suicide Prevention State Plan

2023-2027 EVALUATION PLAN

10.4.24

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Background and introduction

The development of the 2023-2027 Minnesota State Suicide Prevention Plan (https://www.health.state.mn.us/communities/suicide/mnresponse/stateplan.html), hereinafter "State Plan," was a collaboration between the Minnesota Suicide Prevention Taskforce (Taskforce) and the Minnesota Department of Health (MDH) Suicide Prevention unit. The suicide prevention efforts in the State Plan are based on the belief that suicides can be prevented, healing is possible, and help is available. The State Plan outlines two main goals: 1. Improve, expand, and coordinate the suicide prevention infrastructure in Minnesota. 2. Prevent Minnesotans from having suicidal experiences and improve the lives of all those who are struggling, so they know they are not alone, help is available, and healing is possible.

Within the second primary goal of preventing Minnesotans from having suicidal experiences and improving the lives of all who are struggling, there are six sub goals:

- Goal 1: Increase individuals, organizations, and communities' capacity to develop and implement a comprehensive public health approach to prevent suicide.
- Goal 2: Promote factors that offer protection for suicidal experiences across the individual, relationship, community, and societal levels.
- Goal 3: Identify and support individuals who are experiencing mental health challenges or who are having suicidal experiences.
- Goal 4: Strengthen access and delivery of care for mental health and suicide.
- Goal 5: Connect, heal, and restore hope to those impacted by suicide.
- Goal 6: Improve the timeliness and usefulness of data.

The State Plan additionally outlines objectives and strategies for each goal. As a collaborative, interagency effort, the strategies are intended to be enacted by the MDH Suicide Prevention unit, Minnesota Suicide Prevention Taskforce, Community Grantees funded by MDH Suicide Prevention Unit, and other Minnesota state agencies, such as Minnesota Department of Education, Department of Veteran Affairs, and the Department of Public Safety.

An evaluation plan is an important component of a state plan to ensure documentation of implementation, outcomes, and lessons learned. This evaluation plan utilizes a combination of community-gathered, state, and publicly available data, with an emphasis on documenting progress towards goals and impact on prioritized populations. The evaluation plan will also incorporate the Plan-Do-Study-Act (PDSA) model of continuous improvement. This approach, which incorporates periodic reviews of data with the taskforce and other key partners, is effective at translating data to inform programmatic decisions and continuous quality improvement. In preparation for this process, the evaluator reviewed evaluation plans of other states' suicide prevention plans as well as existing data collection processes within the MDH Suicide Prevention unit to find alignment. To create this plan, the MDH Suicide Prevention unit Evaluator worked with the Suicide Data Action Committee of the taskforce to determine the key evaluation questions and the evaluation approach, process and outcome measures in alignment with the defined goals and objectives, and a data dissemination plan. Unique highlights:

- **Value driven.** In the first section of this plan, we outlined the approach and values we will enact throughout the evaluation process. While the details of the methodology might be

adapted over the duration of the plan implementation, the values articulated within the evaluation approach will remain to guide the work.

- **Looking forward while looking back**. The state plan is updated every five years. Progress on the 2023-2027 state plan will be evaluated as we also collect actionable data the taskforce will need to create the next state plan.
- **Considerations for multiple audiences.** To ensure data for learning, this plan culminates with an outline of how data and deliverables will be disseminated to the taskforce as well as various audiences who can use the data for action.

Definition of key terms used in this evaluation plan

Outcome: Describes general benefits related to changes in behavior, skills, knowledge, attitudes, values, condition, status, or other attributes. Outcomes can be short-term, intermediate, and long-term and should align with logic model outcomes. Short and midterm outcomes for the purpose of this plan are defined as outcomes that can be observed immediately after an intervention (short term) or within one to three years of intervention (midterm).

Indicator: Measures achievement and operationalized outcomes; specifically, how the outcome will be measured. Indicators are closely tied to the outcomes and should be responsive to evaluation questions.

Data collection method: How the data will be collected. For example, survey, key informant interview, document review, etc.

Data source: Data source refers to the origin of a particular set of information. For example, if the data can be obtained from an existing dataset or ongoing data collection process, the data source will list the name of the existing database or the data collection system. If the data source requires collecting new data, this section will describe how that new data is being collected, such as interviewing, surveying, etc.

Timeline: Describes the frequency of data collection, data analysis, and dissemination. For example, monthly, quarterly, annually, etc.

Overall evaluation approach

This evaluation is based on the following commitments and priority considerations:

Utility

A key goal of the evaluation is to produce useful, actionable information for the various co-creators of the state plan. Data processes are intended to gather information that is useful for MDH Suicide Prevention community grantees, Suicide Prevention unit staff, and the taskforce. To use data for continuous improvement, the evaluation plan incorporates periodic reviews of data and facilitates collective meaning-making with grantees and other partners, which are effective strategies for translating data to inform programmatic decisions and ongoing adaptation. This evaluation plan is part of the iterative process of creating and updating a suicide prevention state plan every five years. To this end, the plan is designed such that data collected and analyzed in the final year will support the next design phase.

Community accountability and transparency

In addition to sharing data back with key users and contributors of data, the evaluation plan also outlines the timeline for when and how data will be shared to the legislature, state agency

leadership, and community members overall. MDH consistently makes public health data related to suicide and associated risk and protective factors available on their website. Likewise, data generated by the execution of this plan will be made routinely available to Minnesota communities. Evaluation data products will be reviewed by community partners, including people with lived experience in suicide loss and suicidality.

Equity

The National Stakeholder Strategy for Achieving Health Equity defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities"[1]. Equity will be incorporated throughout the evaluation process. This will be done through evaluation questions and data collection processes that surface how and to what extent strategies centered the populations identified as most burdened by suicide. These populations, which were defined in the in the State Plan, include American Indians, youth, middle-aged males, Black, LGBTQ+, veterans, and people with disabilities. The State Plan (https://www.health.state.mn.us/communities/suicide/documents/suicideprevstateplan.pdf) outlines the rationale for these priority populations. This plan recognizes that these categories are not discrete. Intersectional analysis demonstrates that various dimensions of oppression are not additive but complex, meaning the experiences of Native American veterans, for example, may differ from the experiences of veterans overall as well as the experiences of Native American people overall. Likewise, these and other groups are not monolithic; there is vast diversity within any community. Also, disparities differ by outcome as evidenced through state-level surveillance systems; for example, males make up most suicide deaths while females make up the majority of self-harm hospitalizations. An additional layer of complexity, however, is that invisible disparities exist due to mechanisms of data creation, collection, and aggregation as well as disparate access to systems. Suicide deaths, attempts, ideation, and depression are linked with social determinants of health, structural racism, anti-LGBTQ and ableist policies, healthcare access disparities, and other experiences of discrimination based on age, sex, gender, sexual orientation, race/ethnicity, socioeconomic status, geography/urbanization, and veteran status, among others.

Collaborative

The creation of this evaluation plan was led by the MDH Suicide Prevention unit evaluator, in partnership with the Suicide Data Action Team (SDAT), a subcommittee of the taskforce. The final evaluation plan was approved by the full committee of the taskforce. MDH evaluation staff work collaboratively with grantees, partners, and other staff to co-create all evaluation-related data collection tools in an effort to minimize data burden on grantees and community partners and build collective ownership over the evaluation process. While the evaluation plan strives for data alignment across various strategies, MDH staff work with each grantee or community partner to individualize data collection practices as necessary for the unique contexts and capacity of grantees. Tribal Nations grantees share data as determined by Tribal leadership.

Feasibility

This evaluation plan emphasizes what is possible with current MDH Suicide Prevention staffing capacity and anticipated level of involvement by taskforce members, including the Suicide Data

[1] National Stakeholder Strategy for Achieving Health Equity. Rockville, MD: By: National Partnership for Action to End Health Disparities, US Department of Health and Human Services, Office of Minority Health; 2011.

Action Team. Suicide Prevention dedicated staffing currently includes a full-time evaluator for 988, a part-time evaluator for other suicide prevention activities, and a part time epidemiologist. The state Suicide Prevention coordinator will additionally play a key role in the evaluation through ongoing management of the state plan implementation.

Primary evaluation questions

State plan implementation:

1. To what extent were the strategies outlined in the State Plan implemented as intended?

Demonstration of outputs and outcomes:

2. To what extent did the objectives implemented achieve intended short-, mid- and long-term outcomes? *(See logic model below.)*
3. To what extent did the suicide prevention infrastructure in Minnesota expand or improve?

Learning and improvement:

4. To what extent do taskforce members and agency partners find committees and the taskforce structure to be effective and valuable? *(Priority year 2)*
5. How and to what extent are strategies centering the identified priority populations in these efforts? *(Priority year 3)*
6. What do community partners identify as strengths, challenges, and opportunities for improvement? *(Priority year 4*)

Logic model

State Plan Goal	Outputs	Short/ mid-Term Outcomes
1: Increase individuals, organizations, and communities' capacity to develop and implement a comprehensive public health approach to prevent suicide.	# and description of resources developed related to implementation of a comprehensive public health approach # and type of distribution activities (i.e. tabling, newsletter/email, social media, other) to disseminate developed resources # of coalition meetings facilitated # and description of attendees # and topics of technical assistance provided to individuals, organizations, or communities related to suicide prevention Description of who TA was provided to by sector and county # of communities engaged in Zero Suicide	Estimated reach from distribution efforts, # of resource downloads Partners understand their role in suicide prevention Partners feel more equipped to implement comprehensive suicide approach Partners and/or communities implement comprehensive suicide prevention strategies Zero Suicide participants progress in adoption of best practices within the Zero Suicide framework Pathway to Care cohort participants progress in adoption of best practices for comprehensive suicide prevention

State Plan Goal	Outputs	Short/ mid-Term Outcomes
	# of communities engaged in strategic planning for suicide prevention	
2: Promote factors that offer protection for suicidal experiences across the individual, relationship, community, and societal levels.	# and description of resources developed related to lethal means, social determinants of health, and other protective factors # and type of distribution activities (i.e. tabling, newsletter/email, social media, other) to disseminate developed resources # of estimated reach from distribution efforts # of gun locks distributed # and description of people receiving CALM training, safety planning training	Individuals and communities have increased access to resources for protective factors # of resource downloads related to protective factors Training participants build confidence to implement skills learned # of training participants who report having utilized skills to intervene and retention of knowledge gained at 6 and 12mo. post training Partners increase efforts to address Shared Risk and Protective Factors Partners implement policy, system and environment changes
3: Identify and support individuals who are experiencing mental health challenges or who are having suicidal experiences.	# and description of people receiving trainings to promote intervention by formal and informal responders (QPR, ASIST, Changing the Narrative, Mental Health First Aid etc.) # and description of trainers engaged in the trainer network # and description of new people becoming trainers and community speakers (Changing the Narrative, Survivor Voices)	Training participants build confidence to implement skills learned in early intervention # of training participants who report having utilized skills to intervene and retention of knowledge gained at 6 and 12mo. post training
4: Strengthen access and delivery of care for mental health and suicide	# calls, texts, and chats to 988 # of referrals from 988 # of warm transfers from 988 to mobile crisis teams # of statewide workgroups across the crisis continuum Description of engagement with Tribal nations to learn about recommendations to strengthen the mental health system # of learning collaboratives for those working in health care and behavioral health # of organizations engaged in Pathway to Care cohorts # and topics of technical assistance provided to health systems on ways to	Individuals have increased access to mental health care Individuals are connected with services/referrals that are appropriate for their need and preferences Increased referrals and coordination between 988, state resources, and Tribal nations Increased collaboration and partnerships across the provider continuum Zero Suicide participants progress in adoption of best practices within the Zero Suicide framework related to referrals, patient discharge and follow-up care Pathway to Care cohort participants progress in adoption of best practices for

State Plan Goal	Outputs	Short/ mid-Term Outcomes
	strengthen their practices around suicide prevention # of tools identified to provide safer suicide care to subpopulations at risk (including veterans)	comprehensive suicide prevention related to referrals and follow-up care.
5: Connect, heal, and restore hope to those impacted by suicide.	# and description of resources developed related to postvention and survivor supports # of estimated reach from postvention distribution efforts # and description of TA provided to communities to implement postvention # of people trained in postvention	Individuals and communities have increased access to postvention resources # of postvention related resource downloads Partners implement policy, system and environment changes # of Zero Suicide participants who progress in adoption of postvention best practices # of cohort participants who progress in adoption of postvention best practices Training participants build confidence to implement skills learned in postvention # of training participants who report confidence in implementing skills learned # of training participants who report having utilized skills to intervene and retention of knowledge gained at 6 and 12mo. post training
6: Improve the timeliness and usefulness of data.	# of data products available on MDH website that are specifically focused on self-harm behaviors # and description of additional new data and evaluation products disseminated (i.e. regional data briefs, SDAT publications) # and description of people receiving trainings and/or technical assistance on how to access and utilize available data	# of months after year-end that preliminary data products are available # of resource downloads related to data and evaluation products Training participants build data literacy and confidence using data for local planning # of training participants who report confidence in utilizing data skills learned

In conjunction, these efforts seek to result in the following long term intended outcomes:

- Supported, connected communities creating conditions for wellbeing across the spectrum of prevention
- Culturally responsive suicide prevention system
- Decrease in suicide ideation
- Decrease in suicide attempts and self-harm
- Decrease in non-suicidal self-harm
- Decrease in deaths from suicide

Evaluation question by methods

The tables below outline how each of the key evaluation questions will be measured.

State Plan implementation

Evaluation question 1: To what extent were the strategies implemented as intended?

Evaluation type: Process evaluation

Indicators	Methods	Data Source	Frequency	Responsible Staff
Completion of action steps	Progress document	Reported by MDH Suicide Prevention Unit Staff	Annually, June 30th	State Suicide Prevention Coordinator SPU Evaluator will analyze

MDH Suicide Prevention staff will be responsible for continuously updating the progress document. This document includes information on progress towards implementation for each strategy outlined in the State Plan, including denoting when a strategy is complete (if once and done or intended to be done annually) or in progress. The Suicide Prevention evaluator will then be able to report annually on the proportion of strategies completed or in progress for each objective and each goal as outlined in the State Plan.

State Plan outputs and selected outcomes

Evaluation Question 2 and 3: To what extent did the objectives implemented achieve intended short-, mid- and long-term outcomes? To what extent did the suicide prevention infrastructure in Minnesota expand or improve?

Evaluation type: Outcome evaluation selected outputs

Indicators	Methods	Data Source	Frequency	Responsible Staff
# and type of trainings provided, # of attendees, audience description # of communities engaged in cohorts and coalition efforts # of new partnerships # and description of participants in taskforce and subcommittees # and content of TA provided, audience description # and type of awareness dissemination efforts, estimated reach and impressions	Staff and Grantee Reporting Form, latest version available upon request	Reported by MDH Suicide Prevention Unit (SPU) Staff and community grantees	Entries updated monthly	Suicide Prevention Unit (SPU) Evaluator
# of calls, texts, and chats utilizing 988; description of users of the 988 system # of mental health referrals provided; warm hand-offs to crisis mobile	988 Reporting Form, latest version available upon request	988 grantees	Entries updated monthly	988 State Evaluator
#/description tools and resource created; views/ estimated audience reach	Progress document Periodic review of document downloads via Site Improve	Reported by MDH SPU staff	Annually, June 30th	SPU Evaluator, State Suicide Prevention Coordinator

Evaluation type: Outcome evaluation short and mid-term outcomes

Indicators	Methods	Data Source	Frequency	Responsible Staff
Increased knowledge about suicide prevention, confidence in identifying and responding to individuals with suicidal thoughts and behaviors.	Training Post Survey, latest version available upon request	Training participants; all trainers (MDH staff, trainer network, regional coordinators, and comprehensive grantees who provide trainings) are expected to offer post-training link to all participants	Ongoing submissions	SPU Evaluator
Increased collaboration and partnerships across prevention efforts	Staff and Grantee Reporting Form, latest version available upon request	Reported by MDH Suicide Prevention Unit (SPU) Staff and community grantees	Quarterly	SPU Evaluator
Adoption of policy, system and environment (PSE) changes	Staff and Grantee Reporting Form, latest version available upon request	Reported by MDH Suicide Prevention Unit (SPU) Staff and community grantees	Quarterly	SPU Evaluator
Adoption of suicide prevention best practices, PSE changes	Zero Suicide Organizational Assessment, latest version available upon request	Zero Suicide Cohort Participants	Annually	SPU Evaluator
Adoption of suicide prevention best practices, and strategies to address shared risk and protective factors, PSE changes	Pathway to Care Community Assessment, latest version available upon request	Pathway to Care Participants	Annually	SPU Evaluator

Evaluation type: Outcome evaluation long-term outcomes

Indicators	Data Source	Frequency	Responsible Staff
Suicide mortality rates	Minnesota death certificates/vital records; CDC WONDER	Annually	SPU Epidemiologist
Hospitalizations for suicide attempts and/or ideation	Minnesota Injury Data Access System (MIDAS); Minnesota Hospital Association discharge data	Annually	SPU Epidemiologist
Self-reported suicide attempts, ideation, and self-harm	Minnesota Student Survey (MSS); National Survey on Drug Use and Health (NSDUH)	2022, 2025*, 2028*	SPU Epidemiologist

*The MSS is administered every three years, including 2022, 2025, and planned for 2028. The NSDUH is administered by SAMHSA annually. Due to the timeframe covered by the State Plan, outcomes analyses for these surveys will focus on 2022, 2025, and 2028.

Long-term outcomes analysis

To demonstrate the impact of the efforts of the state plan, MDH will use a difference-in-differences (DID) analysis approach to examine the associations between tiers of intervention and suicide mortality, hospitalization, and ideation rates at the county level. The DID approach has been demonstrated to provide a quasi-experimental model for documenting policy and other community-level intervention effects, including documenting impact on suicide rates[2,3]. The DID approach accounts for differences in county-specific rates of outcome measures prior to the implementation of the State Plan. In addition, this type of analysis allows analysts to account for differences in other factors that may have influenced outcomes, such as population density, provided those factors are measurable at the beginning of the State Plan period.

Minnesota counties will be assigned to one of three tiers, based on the level of reported suicide prevention efforts; exact tiers will be defined based on empirical evidence of strategies implemented. As an example of how this may be operationalized, consider gatekeeper trainings. Previous studies have demonstrated that gatekeeper trainings result in lower-than-expected youth suicide mortality rates per county as compared to counties that did not have

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[2] Hyunsuk Jeong, Hyeon Woo Yim, Seung-Yup Lee, Misun Park, Woolim Ko,
The effectiveness of a suicide prevention program in primary care clinics supported by community public health resources: A difference-in-differences analysis, Psychiatry Research, Volume 334, 2024, 115803, ISSN 0165-1781, https://doi.org/10.1016/j.psychres.2024.115803.
(https://www.sciencedirect.com/science/article/pii/S016517812400088X)

3 Raifman J, Moscoe E, Austin SB, McConnell M. Difference-in-Differences Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts. JAMA Pediatr. 2017 Apr 1;171(4):350-356. doi: 10.1001/jamapediatrics.2016.4529. Erratum in: JAMA Pediatr. 2017 Apr 1;171(4):399. Erratum in: JAMA Pediatr. 2017 Jun 1;171(6):602. PMID: 28241285; PMCID: PMC5848493.

gatekeeper trainings. This effect is detectable even after a single year; persistent implementation across multiple years have been associated with larger effects, making this a viable level of intervention for demonstrated effects[4]. If a county implemented gatekeeper training and at least one policy, system, or environmental intervention, they may be designated to the highest intervention tier. Counties that implemented gatekeeper training without policy, system, or environmental interventions may be designated to a lower intervention tier. Counties reporting no evidence-based interventions associated with the State Plan might be in a zero-intervention tier. While this method of analysis will not provide causal evidence, it is intended to demonstrate the impact of synergistic strategies occurring simultaneously within a community. A subcommittee of the Suicide Data Action Team of the State Taskforce will be responsible for determining exact methodology, including how county-level tiers should be assigned, what would be included in those assignments, the statistical methods employed to complete this analysis, and the timeline for this analysis.

Additionally, surveillance data will be used to assess if disparities in death and hospitalizations due to suicide increase or decrease over time for the priority populations identified in the state plan where data is available.

While not specifically an outcome, to ensure final analysis of surveillance data is useful for the next iteration of the state plan, the cumulative analysis of surveillance data will include an intersectional analysis of the MSS for suicide-related indicators, including ethnicity-specific data for identified priority populations as available.

Additional evaluation questions of interest: Learning and Improvement

To supplement the ongoing data collection efforts that will be used to answer the implementation and outcome evaluation questions, three additional evaluation questions were identified; one additional evaluation question will be prioritized each year. The exact methodology will be determined in partnership with the Suicide Data Action Team and Taskforce.

Evaluation question	**Timeline**	**Anticipated methods**
4. To what extent do taskforce members and agency partners find committees and the taskforce structure to be effective and valuable?	Priority year 2; Fall 2024/ Summer 2025	• Survey of taskforce members • Interviews with agency partners, current and previous committee chairs
5. How and to what extent are strategies centering the identified priority populations?	Priority year 3; Fall 2025/ Summer 2026	• Survey of taskforce members, community partners • Interviews with community partners
6. What do community partners identify as strengths, challenges, and opportunities for improvement?	Priority year 4; Fall 2026/ Summer 2027	• Regional listening sessions, engagement with health equity regional networks • Audience-specific focus groups

4 Godoy Garraza L, Kuiper N, Goldston D, McKeon R, Walrath C. Long-term impact of the Garrett Lee Smith Youth Suicide Prevention Program on youth suicide mortality, 2006-2015. J Child Psychol Psychiatry. 2019 Oct;60(10):1142-1147. doi: 10.1111/jcpp.13058. Epub 2019 May 8. PMID: 31066462.

Evaluation data products

Evaluation products include, but are not limited to, detailed reports, presentations, case studies, or peer-reviewed publications. These products are outlined below. In line with the commitment to equity, multiple reports are directed at various audiences and these products will be produced in a variety of ways to broaden the usability of this evaluation.

1. Legislative report
    a. Primary audience: Minnesota State Legislature.
    b. Purpose: In compliance with legislative requirements, provide biennial updates to the legislature on progress towards State Plan implementation and emergent outcomes. Build continued legislative support for suicide prevention efforts.
    c. Format: Legislative report template.
    d. Timeline:

- Data summarizing July 1, 2022-June 30, 2024, for submission by January 2025.
    - Data summarizing July 1, 2024-June 30, 2026, for submission by January 2027.
- Data summarizing July 1, 2026-June 30, 2028, for submission by January 2029.

2. Annual summary brief
    a. Primary audience: Taskforce members and community partners.
    b. Purpose: Tool to highlight work done to date that can be used by partners and taskforce to see how their portion of the work fits into the State Plan and share with local communities about their work.
    c. Format: Written short brief, supplemental PowerPoint slide deck and oral presentation during taskforce meeting.
    d. Timeline: Annually, data summarizing work through June 30 to be distributed each October.
3. Regional briefs
    a. Primary audience: Suicide Prevention Regional Coordinators, local community partners looking for more information about implementation within their specific community.
    b. Purpose: Provide regionally specific summaries combining multiple sources of information of suicide, suicidal ideation, service-seeking behavior and interrelated protective and risk factors alongside relevant region-specific intervention summaries and outcomes.
    c. Format: Written short brief, supplemental oral presentations in partnership with Suicide Prevention Regional Coordinators based on local interest.
    d. Timeline: Biennially, aligning with legislative reporting schedule. Distribution by January 2026 and 2028.
4. Cumulative report
    a. Primary audience: Taskforce members and community partners.
    b. Purpose: Document lessons learned, successes, and review data for adaption for the next iteration of the state plan.

c. Format: Long form report, executive summary; supplemental oral presentation to during taskforce meeting.
d. Timeline: Aggregation of all data collected to date; distribution for 2029.

Additional ad hoc evaluation deliverables will be determined as needed to summarize and disseminate information gathered in response to the evaluation questions four and five.

Future plans

The Suicide Data Action Team identified the following additional suggestions for inclusion into the evaluation plan should resources and timing allow:

- **Case studies to more deeply explore and highlight what is working well.** Based off of the findings from the regional summaries and outcome evaluation, additional data collection could be done in partnership with specific communities who are interested in telling their story. Ripple effect mapping or another form of qualitative data collection co-designed with community partners could be done to better understand local contexts and nuances of implementation as well as surface information to help other communities deepen their prevention efforts.
- **Integration of external evaluation partners.** This current plan is centered on data collected and managed by MDH. Efforts done by external evaluators or researchers in partnership with grantees, other state and local agencies and Tribes are a valuable under-utilized resource that could expand capacity.