Trauma-Informed Wales: A Societal Approach to Understanding, Preventing and Supporting the Impacts of Trauma and Adversity

ACE Hub Wales & Traumatic Stress Wales

Consultation – Summary of Responses

June 2022

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

Overview

This document outlines the responses received to the consultation document 'Trauma-Informed Wales: A Societal Approach to Understanding, Preventing and Supporting the Impacts of Trauma and Adversity' produced by the ACE Hub Wales and Traumatic Stress Wales. Views were invited as part of a consultation period which opened on 16th March 2022 and closed on 17th June 2022.

Enquiries about this report can be directed to:

ACE Hub Wales
Policy and International Health,
WHO Collaborating Centre on Investment for Health and Well-being
Public Health Wales
Floor 5
2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ
Email: ACE@wales.nhs.uk

ACE Hub Wales & Traumatic Stress Wales would like to thank those who gave their time to respond to this consultation exercise.

1. Introduction

The Adverse Childhood Experiences (ACE) Hub Wales and Traumatic Stress Wales have collaborated on the co-production of a National Trauma Practice Framework for Wales that covers all age groups and all forms of adversity and traumatic events. The aim of the framework is to help people, organisations, and systems to prevent adversity and trauma and their associated negative effects. It will facilitate the development of a whole systems approach to supporting the needs of people who have experienced adversity and trauma and seeks to bring consistency and coherence to support that effort and ensure that it meets the needs of those affected by trauma. This extends from the need for empathic, compassionate responses across all Welsh society and more acute and specialist interventions that may be required to support those who have clinical needs following experiences of trauma. The framework provides agreed definitions and a consistency of understanding of what is meant by the different levels of practice in preventing adversity and trauma and supporting people affected by it. The Framework has been developed in partnership with the Welsh Government.

An Expert Reference Group (Annex A) was brought together to advise and support this work; this includes people with lived experience, practitioners from a range of sectors, clinical and non-clinical leads, and academics, to ensure the framework is truly co-produced and which places humanity at its heart.

2. Consultation Process

Prior to Public Consultation

In developing the draft framework, it was ensured that views were sought from a variety of stakeholders, including a range of Welsh Government internal forums. Additionally, existing opportunities through established stakeholder engagement processes were utilised to develop the draft consultation. These groups included representatives from the public and private sectors, third sector, individuals, and communities (Annex B).

Public Consultation

The methods used to gather responses to the consultation process included:

- Public consultation (March – June 2022)
- Targeted meetings and discussions with sectors and representative groups
- In-person formal workshop events (May and June 2022)
- Online event (June 2022)

Public Consultation

Views were invited as part of a consultation period which opened on 16th March 2022 and closed on 17th June 2022. The consultation document was sent out by email to stakeholders of the ACE Hub Wales and Traumatic Stress Wales. These emails were sent to over 1000 recipients from a broad spectrum of organisations, including public and third sector organisations, as well as those with professional expertise, particularly in children and adult mental health services. Additionally, the consultation was hosted on the ACE Hub Wales Website and emails and social media from both the ACE Hub Wales and Traumatic Stress Wales directed people there to view the documents. Tweets and Facebook reminders were used to advertise the events that people could sign up to attend as well as a countdown to the consultation closure deadline. Specific reminders went out on the days prior to the deadline to alert the public when the consultation had closed. Respondents were able to submit their views and comments by email using a response sheet.

Targeted Meetings and Discussions with Sectors and Representative Groups

Additionally, engagement during the consultation period was undertaken with a range of stakeholders (Annex C). This engagement took place in a range of ways including sector specific meetings that ACE Hub Wales and Traumatic Stress Wales were invited to present at, both internally within Welsh Government policy areas and with external networks and groups. There were targeted workshops and meetings with specific groups and organisations whose input needed more detailed discussion than at the more cross sector, public workshops. These included for example, discussion that included for example, the experiences of poverty, racial marginalisation, and other marginalised groups in Welsh communities, or representing specific concerns such as barriers to support for care experienced people, refugees and displaced people, those with neuro-diverse conditions, and organisations that directly work with children and young people.

In-Person Formal Workshop Events

During the consultation period, four formal consultation workshops were undertaken across Wales (Annex D); these reached over 300 people. The workshops were advertised on social media, via stakeholders and through targeted conversations with key partners locally and regionally to encourage maximum participation across professionals in the public/private sectors, community-based organisations, and individuals. Each session began with a presentation of the framework, participants were then asked to discuss the consultation questions on tables and provide written feedback on some or all of them. The feedback was collected and analysed in terms of responses to each of the ten questions with key themes summarised. At each event, use of the Welsh Language was encouraged, and simultaneous translation provided. Each venue was chosen based on accessibility and facilities to support those with any particular needs in attending.

Online Event

One online event was undertaken on 6th June, advertised by both Traumatic Stress Wales and the ACE Hub Wales on social media and via targeted emails. The event attracted over 40 participants from a range of sectors but with a strong representation from specialist organisations in health and mental health. The format for this event was a presentation and question and answer session.

3. Summary of Consultation Responses

This section provides a summary of feedback, both from the written consultation responses and feedback from the in-person events. There were 76 written responses to the consultation (a list of respondents by organisation can be found at Annex E); 8 respondents wished to remain anonymous. The consultation received responses from a range of organisations and service providers, consequently, the feedback included a range of views which were at times, conflicting. Analysis attempted to reflect the full range of comments and strike a balance between varying viewpoints. Overall, comments were supportive of the structure of the document, the tone, the principles and practice levels. Constructive feedback centred on language, terminology and framing of meaning as well as some very helpful additional areas to include. This report is presented according to the ten consultation questions, however, it does not seek to include all comments but rather to summarise key themes and issues.

Q1: Before reading this document, how familiar were you with the concept of a trauma-informed approach? Do you agree it should be a priority for everyone in Wales?

From the written responses, the vast majority of the respondents were familiar with the concept of a trauma-informed approach, however it was noted that the framework provides a greater clarity and a clearly focused definition. The consensus was that a trauma-informed approach should be a priority across Wales, since trauma can affect the way that individuals interact with service provision and the lack of a trauma-informed response can create barriers to engagement. At the in-person events, stakeholders observed that definitions will vary from place to place and across different professions, so clarity is essential, also an 'all Wales' approach is needed to ensure consistency. Finally, it was felt that the framework should underpin all legislation and practice in Wales and be subject to monitoring and review.

Q2: We would like to know your views on the aims of this framework, specifically whether it reflects the experience of adversity and trauma

From the written responses, many respondents felt that the aims of the framework are comprehensive and informative, it was also stated that the framework should be commended for its sensitivity and awareness. It was suggested that it is not clear how trust and 'join up' between services will be achieved, also that it would be helpful for the aims to include a clear pathway for information sharing between services. It was also noted that while it was positive to see a life span approach to trauma, the importance of applying a whole approach, including recovery and empowerment to older age groups needed to be explicit. Babies, children and young people were also highlighted as a group which need to be explicitly referenced within the document. From the in-person events, there was agreement that the aims reflect the experience of adversity/trauma but more work was needed to explain what re-traumatisation is and the need to separate the person from the trauma.

Q3: Is there anything missing in the overall approach set out in this document?

From the written responses, respondents highlighted several areas where more detail was needed. One was that there needs to be a focus on trauma-informed staff support and this needs to be embedded in trauma-informed organisations. Staff support could be in the form of training but also emotional support and specialist intervention when required, in recognition that staff

may also have ACEs and trauma in their background but that they may also suffer from vicarious trauma. Another area highlighted as missing was reference to the impact on an individual's behaviour if they have been impacted by traumatic experiences and how the trauma-informed approach can help others understand those behaviours. It was noted that it would be useful to see more emphasis on including communities to ensure that they are key to any service development. Finally, that the document needs to be clearer in terms of how it aligns with legislation.

At the in-person events, stakeholders also highlighted the importance of supporting staff. Also, that working in a more trauma-informed way may include the need for more resources and that it may result in 'bumping up' against competing frameworks. It was stated that the framework needs to emphasise the complexity of individual needs (substance misuse/asylum seekers/special needs/language) and also that the benefits of this approach should be made explicit.

Q4: Thinking about the definition of a trauma-informed approach proposed in this document, is there anything missing?

From the written responses, the definition provided by the framework was described as comprehensive, broad, extensive, well-explored and inclusive. However, it was suggested that it may be helpful to develop an acronym or abbreviated definition to assist greater understanding. A further strength of the definition identified is that recovery can take a non-linear trajectory, however, it was felt that there is a lack of emphasis on the empowerment of the individual who has experienced the trauma within the definition, with a focus on those around them recognising the effects of trauma and 'doing to' the individual. It was also stated that the definition fails to mention that the impact of trauma may present in multiple and complex needs which need to be approached through partnership and on a needs-led basis. A further suggestion was to replace 'creating opportunities' with 'facilitating opportunities', this was felt to be more appropriate since this provides an opportunity for the individual to self-develop. It was also felt that fictional examples throughout would be helpful.

Feedback from the in-person events included that resilience as a word/concept should be added. Also, that some of the language used is pathologising, for example 'signs and symptoms'. The reference to the whole community in paragraph 4 was appreciated. In terms of the language, 'for people' should be 'with people' and journey should be used instead of pathway. It was felt

that trauma and trauma-informed response should be better linked to human rights and that compounding and multiple oppressions are not sufficiently explicit in the definition. Also, that the definition of trauma needs to be stronger and draw on other more inclusive definitions (e.g., trauma framework for people with learning disabilities). Finally, that the strong paragraph relating to social determinants needs to filter throughout the document.

Q5: The approach set out in this framework is underpinned by 5 practice principles; are they right? Is anything else that should be included?

In the written feedback, the five practice principles identified within the framework were described as good, excellent, and well thought out although one respondent suggested that numbering them may be useful. Suggested amendments to the principles included more emphasis on staff and staff support; rephrasing 'A universal approach that does no harm' to 'Commitment to personal safety'; and for the term 'intersectionality' to be added to the fifth principal to ensure the approach is responsive to multiple areas of marginalization and to ensure it ties in with a person-centered holistic approach. It was emphasised that the principle of working towards community cohesion is important since there is a danger that families are singled out as having issues around trauma/ACEs, this was echoed by another respondent who noted that acknowledging supporting the role of informal community networks in addition to the organisational response was positive.

Feedback from the in-person events included the view that the principles were good, but the infographics were too wordy. It was also brought up that the term 'do no harm' may be intimidating for non-medical and less experienced staff. It was observed that the tendency to group individuals together as 'BAME' does not recognise the different cultural experiences which would inform most the appropriate response and there is a need to ensure that there is diverse representation. It was also noted that the immigration process is traumatising. Finally, it is necessary to look at how the principles fit into sector specific frameworks.

Q6: The trauma-informed practice framework has four practice levels. Are the difference between each of these levels clear, and can you see who they might be aimed at?

In the written feedback, most respondents felt that the levels were clear and explained well. However, it was felt that examples of services, individuals and organisations at each practice

level would be helpful, also the acknowledgment that individuals may be accessing different practice levels simultaneously. It was also felt to be important that the practice levels 'speak across' to each other so that there is consistency and join-up in terms of provision. It was suggested that there may be a bottleneck, with lots of level 1-3 but a lack of level 4 and finally, that it would be helpful to provide training packages that are able to support delivery against each of the practice levels.

At the in-person events, it was suggested that the word 'level' creates a hierarchy of offer, and 'spectrum of service' may be an alternative phrase. This was echoed by another group who suggested that the hierarchical structuring of the levels may be problematic, and they may be better presented in terms of a continuum since it is often appropriate for organisations to exist on several levels. It was highlighted that there is a need to make sure that when moving between levels, support from other levels doesn't disappear and to ensure that funding is allocated to support all levels. Also, the need to provide more detail about what needs to be in place at each level, including training and support/supervision in measurable ways, for example a benchmark in respect of what levels look like and what can be expected. Other comments were that there could be an outline of individual and organisational differences; there is a need for accessible versions of the document and that trauma-skilled and trauma-enhanced should have a category added for community leaders, faith groups etc. Finally, new service teams that provide support to have to identify what level of the model they are aiming to work towards which can then support local mapping of services.

Q7: Within the practice levels, is the support that might be received in each level clear, and do you have any further examples of what good looks like in relation to this?

In the written responses, many respondents felt that support in each level is clear, some respondents picked up on 'support is available in workplace to all who need it' noting that the availability of support is often insufficient, and barriers exist to accessing support. It was suggested that new staff should be made aware that they may be exposed to traumatic events and within the trauma-aware level there would be some benefit in highlighting what this exposure means, what might arise as a result and what support there is in place to deal with it.

It was suggested that 'good' in relation to this could be for those who are trauma-informed to be able to know where to find the information to signpost effectively to services that are impactful when accessed when they recognise potential experiences of trauma. 'Good' may

also include organisations having the capacity to provide the right level of support at the right time in response to a potential increase in referrals when understanding and awareness of being trauma-informed is embedded and people recognise the need for that support as an early intervention. Finally, it was suggested that good vs bad or trauma-informed vs not trauma-informed examples might be good, alternatively, examples of fictional case studies or vignettes may be useful.

In the in-person event, it was suggested that a column of 'what good looks like' would be useful. Also, it was questioned how this will be implemented.

Q8: Thinking about trauma-informed organisations and systems, is it clear how the definition, 5 principles, and practice framework applies?

In the written responses most respondents felt that it was clear, however, it was noted that while it is clear how they work in theory, an action plan/flow diagram of how it would all work in practice may be useful. In particular, how agencies work together with 'equal power' and challenge silo working. Additionally, it was suggested that there would be resource implications, both financially and physically to enable services and organisations to respond effectively. It was suggested that the framework needs to read across into existing operational practice and trauma-informed care models. There should be links to tools and resources to support the workforce and their application of the framework

In the in-person event feedback, it was questioned if there would be specific streams for all protected characteristics, also if there would be legislative change to underpin the framework.

Q9: The practice framework aims to exemplify the approach it sets out; does it achieve this in the tone, language and inclusivity of diverse lived experience?

In the written feedback, most of the respondents felt that the framework aims did exemplify the approach it sets out, with one respondent suggesting it was inclusive in language, tone and content. However, it was suggested that not enough reference was made to intersectionality and diversity, also it does not account for victims of trauma who experience multiple barriers to accessing support services e.g., women exploited by the sex industry. It was also suggested that it needs to be presented in several ways for different groups to understand and process the information, for example an easy read version. It was also suggested that the lived experience element could benefit with some short, anonymised case studies setting out the wide-ranging

impacts of trauma and where interventions have worked to address this. Further, consideration needs to be given to staff who may recognise their own experiences of trauma because of this approach and ensuring the support is available for them to be able to process this.

Q10: We want to understand your thoughts on implementation of the framework. What are the challenges to putting this into practice, and what else might you need to do so?

In the written feedback, challenges identified include sufficient time is given to embedding this framework and ensuring the availability and accessibility of resources. However, it was noted that there will be a need to access good trauma-informed training at reasonable cost, though additional training will require additional human resources, and this may pose a challenge. Also, that trauma-informed and enhanced care will require regular, ongoing, embedded trauma-informed reflective practices and organisations may struggle with cost and staffing resources to implement the framework so there may be a need to support with additional financial resources. It was also noted that it is essential that a process of evaluation with a clear mechanism for reviewing implementation is considered.

It was noted that given that the framework must apply to both devolved and non-devolved services in Wales, careful consideration will need to be given to consistent implementation and how this can be embedded within organisational learning and development. A challenge could be in strategic engagement across partnership bodies, ensuring a common approach as well as challenges of how to communicate the information, using a variety of approaches but also ensuring robust and appropriate support mechanisms to respond to the level of need once awareness and understanding is raised. Further, the current system does not support CPTSD except with medication and there needs to be more compassionate spaces that are attuned and feel safe, overseen by someone who understands and has lived experience. Finally, who will monitor and regulate the quality of provision and the suggestion that this approach needs to be backed up with legislation.

At the in-person events, challenges identified included time, money and resources and changing the perspectives of staff. Other challenges include collaborating with agencies without the same ethos and the potential for other agencies to re-traumatise clients or service users; access to mental health services is problematic and this will have an impact on other systems; a one size fits all approach will not work and can lead to a person being labeled as non-engaging. Finally, the workforce needs to feel valued and decision makers need to be free

to make good trauma-informed decision without barriers.

4. ACE Hub Wales & Traumatic Stress Wales Response

The overwhelming consensus of the feedback was that a trauma-informed approach was welcomed, and in many cases was already being championed within organisations. Also, it was felt by the majority of the respondents that utilising a trauma-informed approach should be a priority across Wales. Further, the framework received an overwhelmingly positive response with one respondent commending it for its 'informed, ambitious and holistic approach to mitigating the impact of adversity, trauma and distress'.

The responses were broadly positive and recognised the contribution of the framework document, there were a number of recurring themes in the feedback, these have been incorporated as changes to the framework document.

Language

Feedback emphasised the importance of inclusive language. Some respondents noted that the language used in the framework is aimed at a professional audience. To ensure equity of access, a plain English summary, companion documents and other resources for a range of audiences, including specific populations such as children and young people, will accompany the framework.

Age

While the framework is age inclusive, it was noted that this was not always explicit in the text and additional references have been incorporated, for example, babies, children and young people.

Finding the balance between different theoretical, ideological and practical approaches

The framework has been strengthened to reflect different paradigms and models as well as the multiplicity of factors which can contribute to trauma which were included in responses. The framework acknowledges that there are strengths and limitations to many of the different approaches, and puts forward a balanced view based on this. Respondents also highlighted the need to be aware of intersectionality and diversity and the importance of these in understanding the often multi-dimensional complexity of the experience of adversity and trauma and the framework has been amended to reflect this.

Strengths based and inclusive approach

Other changes made to the framework reflect the need to acknowledge that people of all ages and backgrounds are affected by adversity and traumatic experiences and that people do not have to experience trauma or adversity to have significant needs and experience emotional distress. Further that people's reactions and needs will be shaped by co-existing factors. As a result the framework was updated to reflect the need for a strengths-based approach, recognition that people will not always follow a linear pathway and that there may be barriers in terms of accessing support.

Aims of the Framework

The aims section has been amended to one single aim and five objectives. Changes to the objectives encompass a recognition of the importance of consistency through services, organisations and sectors and the need to have effective and secure systems for sharing information. In terms of the practice levels, reflecting feedback, it is noted that the levels represent a spectrum rather than a hierarchy, in recognition that many people affected by traumatic events will need support from different levels at the same time.

Legislative and Policy Context

References to the wider context of the framework have been strengthened and developed, including reference to a human rights and children's rights-based approach as well as wider legislative, policy and other frameworks. These include legislation such as the Equality Act 2010; Welsh legislation: for example the Social Services and Well Being (Wales) Act 2014; international instruments such as the United Nations Convention on the Rights of the Child; and policy in Wales and wider including More than Words and the Taking Time Framework.

Implementation

In response to the final question around implementation, we are clear on the need for a more accessible, plain English version, as well as a children and young people's co-produced document. In addition it is clear that vignettes, case studies or animations would be important to bring the framework to life. All of these responses, and the additional suggestions put forward will now be put forward to the implementation phase of this work. We will also look to establish a governance structure that enables specific work streams on areas that may require more detailed focus and we will look to the Implementation Group to advise on what they should be and who should be involved.

Annex A: Expert Reference Group Membership (Listed Alphabetically)

Name	Organisation	Role
Caroline Hughes	Wrexham Glyndwr University	Associate Dean
Ciaran Humphries	Public Health Wales	Consultant in Public Health
Clare Crole-Rees	Traumatic Stress Wales	Psychological Therapies Lead
Dave Williams	Traumatic Stress Wales; Welsh Government; UK Trauma Council	Consultant Psychiatrist
David Pearce	Welsh Government	Policy Lead (Children and Families Division)
Elizabeth Gregory	AB UHB	Consultant Psychologist in CAMHS
Emma Wools	Police and Crime Commissioner	Deputy Police and Crime Commissioner
Ewan Hilton	Platform	Chief Executive
Jo Hopkins (Co-Chair)	ACE Hub Wales, Public Health Wales	Programme Director for ACEs, Criminal Justice and Violence Prevention
Joanne Maddaford	Welsh Government	Policy Lead (Health and Social Services Group)
Prof Jon Bisson (Co-Chair)	Traumatic Stress Wales; School of Medicine Cardiff University	Director of Traumatic Stress Wales; Clinical Professor in Psychiatry.
Julia James	MIND Cymru	Programme Manager
Michael Davitt	Member of the Public/Person with Lived experience	TSW Public Advisory Group Representative
Nicola Evans	Welsh Government	Policy Lead (Health Inequalities and Health Communities)
Nicola Massie	National Psychological Therapies Management Committee	Consultant Psychologist
Sara Dodds	Scottish Government	ACEs and Resilience Unit
Sarah Crawley	Barnardo's Cymru	Director
Sue O'Leary	MIND Cymru	Head of Operations
Suzanne Duval	Diverse Cymru	BME Mental Health Manager
Tegan Brierley Sollis	Wrexham Glyndwr University	Teaching Assistant; Project Lead TrACE University
Tom Hoare	Traumatic Stress Wales	Psychological Therapies Lead (Children and Young People)
Vicky Jones	ACE Hub Wales	Deputy Lead

Annex B: Stakeholder Engagement Pre-Consultation

Violence Prevention Unit, Public Health Wales
Diverse Cymru
Platform
NSPCC
Health and Care Research Wales

Annex C: Stakeholder Engagement Consultation

Platform
WLGA
Public Health Wales, National Safeguarding Network
Home Office
Wales Strategic Migration Partnership

Annex D: In-Person Stakeholder Engagement Events

Event	Location	Date
1	Aberystwyth	4th May 2022
2	Newport	19th May 2022
3	Swansea	25th May 2022
4	Llandudno	7th June 2022

Annex E: Consultation Respondents

	Organisation
1	Cardiff &Vale UHB (Individual)
2	Anonymous
3	Cartrefi Conwy
4	Police Liaison Unit (Individual)
5	Public Health Teams, Betsi Cadwaladr UHB
6	Bridgend College
7	Cardiff &Vale UHB
8	Aberystwyth University/The Wallich
9	Dewis Choice, Centre for Age, Gender and Social Justice, Aberystwyth University
10	Thrive Women's Aid
11	Pembrokeshire Care Society
12	Coleg Gwent
13	Vale of Glamorgan LEA
14	NHS
15	The Wallich
16	Anonymous
17	Neath Port Talbot
18	National Youth Advocacy Service
19	Family and Therapies, Aneurin Bevan UHB
20	Youth Justice Board for England and Wales
21	Individual Response
22	Hafan Cymru
23	New Pathways
24	Anonymous
25	Anonymous
26	Conwy County Borough Council
27	The British Psychological Society
28	National Association of Principal Education Psychologists – Cymru (NAPEP-C)
29	Psychology Dept., Older Adult Directorate, Aneurin Bevan, UHB

30	Adferiad Recovery
31	Pembrokeshire College
32	Liberty Care Ltd, Aneurin Bevan UHB, Learning Disability Psychological Services
33	Stepping Stones, North Wales
34	Gwent Parent-Infant Mental Health Board, Aneurin Bevan UHB
35	Welsh Psychotherapy Institute
36	NSPCC Cymru
37	Welsh Health Specialised Services Committee (WHSSC)
38	Samaritans, Cymru
39	Public Health Wales, Aberaeron Integrated Care Cymru
40	ClwydAlyn Housing Ltd
41	Family Friends
42	Gwent Attachment Service, Aneurin Bevan UHB
43	Child and Family Psychological Health Service, Aneurin Bevan UHB
44	Social Care Wales
45	Children and Families Division, Welsh Government
46	Anonymous
47	New Pathways
48	Hywel Dda Public Health Directorate, Hywel Dda UHB
49	Adult Mental Health Psychology & Psychological Services, Betsi Cadwaladr UHB
50	Trauma Informed Schools, UK
51	Home-Start Cymru
52	Carmarthenshire Educational and Child Psychological Service, Education and Children's Services
53	Royal College of Psychiatrists
54	Llamau
55	Children in Wales
56	Project Unity, NYAS
57	Welsh Women's Aid
58	Monmouthshire County Council
59	Anonymous
60	Anonymous
61	The Wallich

62	The Children's Commissioner for Wales
63	Swansea Bay UHB
64	Coleg Cambria
65	Mental Health Clinical Board (MHCB)
66	Children's Legal Centre Wales and Observatory on Human Rights of Children
67	Save the Children/Platform
68	Psychologists for Social Change Cymru
69	The Anna Phillips Foundation
70	Platform
71	Barnardo's
72	Adult Learning Wales
73	Powys Children's Services
74	Physical Health Psychology, Aneurin Bevan UHB
75	Anonymous
76	Office of the Future Generations Commissioner