

Working together to find a voice: Recommendations for voice healthcare based on expert-by-experience and practitioner consensus

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Abstract

Objectives: Voice care services aim to provide effective and meaningful voice care. Current practice guidance recommends a multidisciplinary voice care approach, supported by the evidence-base and practitioner experience. However, unlike other areas of physical and mental health, current voice care guidance does not explicitly include the voices of experts-by-experience, meaning those who have lived experience of voice difficulties. The perspectives of those working within non-clinical voice professions, such as vocal coaches, are also often omitted. There is therefore a need for updated practice guidance which prioritizes expert-by-experience and non-clinical perspectives. **Methods:** Vocal Health Education hosted a consensus meeting in London, UK. The meeting was coproduced with experts-by-experience, and attendees included those with lived experience of voice difficulties and practitioners across a range of disciplines within voice care. The content of the meeting was synthesized into themes and associated recommendations were drafted and agreed to by all attendees. **Results:** The consensus statement offers practical advice to those working in voice care. Recommendations are offered for multidisciplinary and biopsychosocial voice care, with a focus on person-centered practice and the valuing of lived experience. Through discussion, consensus was reached regarding recommendations for voice care assessment and treatment, practitioner approach, psychosocial considerations, and service design. The need for greater expert-by-experience involvement, coproduction, and co-construction was emphasized throughout. **Conclusions:** This report emphasizes the voices of those with lived experience. It highlights ways of updating or improving current care, with the aim of informing clinical practice as well as research and service development. The consensus statement is the first in voice care to include experts-by-experience at the center of its recommendations, underlining the need for more coproduced and co-constructed research and practice within voice healthcare.

Key words: consensus; lived experience; best practice; vocal health; biopsychosocial

INTRODUCTION

Voice care services aim to provide specialist support to individuals experiencing voice difficulties. Voice difficulties might include problems with vocal pitch, quality, volume, or flexibility¹, spanning functional and organic diagnostic categories². In the UK, voice services sit within tertiary care³ and provide expert voice assessment and treatment, often following referral from other healthcare and/or voice professionals. Professional guidance^{4,5} emphasizes multidisciplinary approaches to voice care, with involvement of practitioners across a range of specialties including voice-specific speech and language therapy (SLT), laryngology, voice science, manual therapy, psychology, and singing and vocal coaching^{6,7}.

Specialist voice care services meet considerable clinical need. Prevalence estimates suggest 1.7% of the general population are affected by clinically significant voice symptoms¹, with ever-increasing rates of referral for specialist support⁸. The increased demand for specialist voice care is likely augmented by the COVID-19 pandemic which has seen a rise in voice-related symptoms^{9,10} in combination with heightened service pressures and stretched resources. Furthermore, service demands are expected to increase in-line with our aging population¹¹ and the voice difficulties that often affect older people^{12,13}. These indicators of clinical need highlight that voice care services must be prepared to provide accurate and effective multidisciplinary voice assessment and treatment. However, long waiting times¹⁴, complicated pathways towards voice care³, and mixed evidence and opinions regarding treatment efficacy^{15,16}, can make it difficult for services to provide care that is timely, appropriate, and meaningful.

In response, there have been several efforts to outline suggestions for best practice in voice care^{5,17-21}. There is agreement that voice care services should be multidisciplinary, with multi-modal assessment and treatment (i.e., imaging, functional assessment, self-report, peer-report). Best practice suggestions account for advancements in telehealth and indicate that some aspects of voice care can be facilitated remotely^{22,23}. There is an appreciation for joint voice clinics¹⁴, with SLT-led services reporting positive treatment outcomes and low re-referral rates²⁴. Across the best practice suggestions cited above, there is recognition that voice care should be tailored to the individual and follow both evidence-based practice and practice-based evidence^{16,25}.

The voices of experts-by-experience (EbE) are sadly missing from many of the best practice suggestions outlined above. There are several studies²⁶⁻²⁸ exploring lived experience of voice difficulties, but these are yet to be translated to inform clinical practice. Indeed, there is a movement within healthcare more generally to involve EbE in the planning, implementation, and evaluation of services (e.g., lived experience perspectives on support following laryngectomy²⁹), with recent consensus statements regarding best practice in physical and mental health³⁰⁻³³ positioning lived experience perspectives at the center of practice recommendations. This then raises questions about why there appears to be a lack of EbE involvement in the development of best practice recommendations for voice care specifically.

The present study therefore involves EbE in the creation of a joint consensus on voice healthcare. It seeks to provide consensus on voice care priorities, covering assessment and treatment, practitioner approaches, psychosocial considerations, and service design. It explores client experiences with the aim of providing practical guidance on how to best support those experiencing voice difficulties.

METHODS

Vocal Health Education (VHE; <https://www.vocalhealth.co.uk/>) hosted a meeting in London, UK, on 16th October 2022 where those with lived experience of voice difficulties, speech-language therapists, a medical doctor, mental health professionals, and vocal coaches convened to discuss biopsychosocial approaches in voice care and vocal health. No service leaders from within the national health service were present. Five attendees are currently in senior leadership roles within private sector multi-disciplinary voice clinics, such as the Voice Care Centre, and therefore have experience of service design and implementation. Most other attendees have experience designing, funding, and leading private sector voice organizations, many of which are private vocal coaching practices. All listed authors attended and contributed material to the meeting. The meeting included a series of presentations about biopsychosocial topics in vocal health and featured testimony from EbE with lived experience of voice difficulties.

The presentations were followed by short question-and-answer sessions, with discussion facilitated by authors SK and JW. All content was audio and video recorded. Authors LF and LAW took notes throughout the meeting, later re-reviewing the meeting content to consolidate their written notes. LF and LAW then jointly created written summaries of the meeting content and its overarching themes. The corresponding manuscript was then created collaboratively with all authors, ensuring consensus on all identified themes and recommendations prior to finalization. The manuscript thus includes the perspectives of all authors, capturing both lived and professional experiences.

Ethics Statement

Not applicable (no ethical approval required).

Funding Statement

The meeting was hosted by Vocal Health Education. No authors received funds for attending the meeting or writing the manuscript.

Availability of Data and Materials

Not applicable.

RESULTS

Themes identified during the meeting are described below, with relevant recommendations associated with each theme presented in Table 1. A matrix visualizing the recommendations is provided in Figure 1. Themes and recommendations are offered with the aim of providing practical advice to those working with individuals experiencing voice difficulties.

Assessment and Treatment

Assessment Process

Attendees agreed that all clients experiencing voice difficulties presenting to services should be offered multidisciplinary assessment. In the first instance, this should include an examination by a laryngologist, followed by assessments with an SLT and a voice coach. It may be that other assessment routes (for example SLT then laryngologist) are necessary amidst time or service pressures. Practitioners within other specialisms (such as psychology, occupational therapy, social work) should be consulted as and when required and/or when requested by the client. It was agreed that a collaborative approach is required which includes the perspectives of all involved voice professionals (i.e., all practitioners holding information relevant to the client's care, including those working outside of a clinical context, for example vocal coaches). As with all healthcare services, assessment should screen for comorbidities and other presenting health difficulties. Referral or signposting should be considered in cases where other health needs may be more immediate than voice-related work. It is the responsibility of voice services therefore to maintain links with primary care services to facilitate referral to other services when required.

It is vital that client occupation be considered throughout assessment. It is widely recognized that some professions (singing/speech performers, teachers, call-center operators) are at greater risk of developing voice difficulties because of the vocal demands of their workload³⁴⁻³⁶. We acknowledge that most practitioners are acutely aware of their client's occupational needs, but the perspective of some attendees was that constraints within the voice care system (see *Stigma and Barriers to Help-Seeking and Service Design*) can make it sometimes difficult for occupational factors to be considered fully. EbE explained that it is helpful to work with a practitioner who intimately understands the demands of their profession, leading to more specific and precise assessment³⁷ as well as a greater shared understanding and alliance. Within this, it is of course important to recognize that personal experience of client occupation needs to be integrated with professional knowledge and expertise.

Attendees agreed that psychometric assessment is an important part of the assessment process. In addition to examination and functional assessment, clients should have the option to complete sensitive and specific self-report measures of vocal health. Example measures include the Voice Handicap Index³⁸ and the Voice-Related Quality of Life³⁹ scales. Relevance of occupation is again important here. For example, if working with singers, assessors should consider using self-report measures relevant to this population, for example the Evaluation of Ability to Sing Easily⁴⁰ or Singing Voice Handicap Index⁴¹. Incorporating these measures within assessment might improve client engagement with the assessment and might make it easier for practitioners to identify presenting problems or areas for intervention.

During their testimonies, EbE with lived experience of functional difficulties (i.e., voice difficulties in the absence of organic pathology) emphasized the importance of compassionate and non-judgmental assessment. EbE described feeling misunderstood by practitioners previously and reported difficulties with getting practitioners to understand their goals for assessment. Practitioners affirmed the

importance of compassionate and person-centered practice, with a collaborative focus towards identifying factors which precipitate and maintain functional difficulties. Practitioners recognized that professional accountability and multidisciplinary working are important when responding to, and correcting, the poor assessment experiences of some clients with functional voice difficulties.

Biopsychosocial Formulation

Practitioners and EbE highlighted the importance of biopsychosocial formulation. Formulation runs alongside diagnosis and can be used to develop shared understanding of client presentation. The meeting focused on formulation, rather than diagnosis (as diagnostic considerations in voice care have been covered extensively previously^{2,42}), including the integration of biological, psychological, and sociological factors in voice use. The '5 Ps' framework of formulation was discussed, drawing on precipitating, perpetuating, predisposing, and protective factors (see Figure 2). There was particular focus on perpetuating factors, with several practitioners and EbE stating how maintenance behaviors (such as hypervigilance, avoidance, compensatory strategies) contribute to ongoing voice difficulties. There was discussion regarding the importance of past experiences and EbE encouraged practitioners to gather historical information during assessment. Some practitioners identified time-pressures and uncertainty about scope of practice when history taking as barriers to this. It was agreed that all formulations should be developed collaboratively with the client and should incorporate multidisciplinary perspectives where possible.

Treatment Selection

Attendees discussed the range of interventions available for selection in vocal health⁴³, with SLT-led voice therapy as the primary therapeutic modality. Both practitioners and EbE recognized that the evidence-base for clinically meaningful, standardized, therapies in voice care is somewhat lacking⁴⁴, with mixed results of voice therapy within voice disorder populations^{15,44}. It is important for practitioners and clients to approach the intervention collaboratively, which means practitioner-client shared discovery and joint exploration of intervention strategies which may be helpful. It does not mean that all involved practitioners are required to provide direct intervention. Intervention should of course be based on information gathered during assessment and the corresponding working formulation.

It is necessary for practitioners and clients to jointly think about how the selected intervention fits within the client's daily life. Thought therefore needs to be given to home/work environment and practitioners must consider whether take-home exercises are feasible and meaningful before prescribing. Practitioners should also be encouraged to be flexible and accommodate reasonable adjustments, for example being open to shorter sessions or less time-intensive take-home exercises.

Practitioners and EbE reflected on the importance of building a therapeutic narrative. Practitioners spoke about using storytelling to externalize the problem outside of the individual⁴⁵ and discussed developing strengths-based, rather than problem-based, narratives during intervention. Attendees agreed that developing a therapeutic narrative requires a range of therapeutic interpersonal skills, such as empathy and active listening.

The potential iatrogenic effects of intervention were also discussed. EbE and practitioners shared that therapy might become unhelpful (and even harmful) if techniques are applied inappropriately or if practitioners work outside of their scope of practice or lack appropriate supervision. It is also important to consider that many specialties within vocal health and voice care (e.g., vocal manual therapy, vocal coaching, vocal rehabilitation) are unregulated (at least within the UK), and thus it can be hard to guarantee practitioner accountability or reporting following iatrogenic effects. Clearly this needs to be considered by practitioners before engaging clients in vocal health interventions.

Practitioner Approach

Speech-Singing Continuum

There is increasing interest in the use of speech and singing principles within voice care. Indeed, several studies^{46–48} have shown that drawing on singing techniques when working with the speaking voice can be beneficial for vocal performance, and vice versa. In keeping with this, meeting attendees explained that it can be helpful to use a variety of singing and speaking techniques during voice assessment and treatment. This raises questions about where boundaries lie between different voice specialisms, and which practitioners should work with which parts of the voice⁴⁹. Consensus was that practitioners should be prepared to draw on techniques from speech and singing disciplines.

Therapeutic Relationship

It was recognized that a mutual, collaborative, and meaningful therapeutic relationship can lead to improved voice care outcomes, with attendees suggesting that the therapeutic relationship is as important, if not more important, than the therapeutic modality itself. It was recognized that active listening, empathy, and compassion are central to building a therapeutic relationship, and attendees suggested that self-reflexivity, self-awareness, and flexibility are also important. Practitioner self-care was also emphasized, with reference to evidence suggesting that practitioner self-care is associated with more positive care outcomes^{50,51}. It was agreed that practitioners should have the opportunity to develop these skills through supervision and training, with the aim of improving client experiences of interactions with vocal healthcare practitioners.

Attendees suggested that there should be more focus on person-centered healthcare approaches within voice care. Person-centered approaches are characterized by working relationships which demonstrate connection, collaboration, and partnership, underscored by social and interpersonal ethics and professional skills⁵². Attendees agreed that, in voice care, this means putting the client at the center of the (collaboratively developed) care plan and prioritizing their needs and goals. Authors LF and SK⁵³ offer a framework (EQUATION) for consent and contracting in vocal manual therapy which, if followed, could be seen as a person-centered approach to voice care. The framework tries to address power dynamics and encourages practitioners to actively involve clients in planning and shaping their care.

Complementary and Integrative Therapies

Previous research⁵⁴ has suggested that professional voice users, for example singers, are more likely to engage with complementary and integrative therapies (CITs) than the general population. This was consistent with the experience of attending EBE and practitioners, many of whom have experience using CITs to look after their own voice or the voices of others.

There was debate about how CITs are perceived by healthcare providers. It was agreed that skepticism towards CITs is at least partly driven by the lack of good quality evidence for their effectiveness in voice care (see narrative review⁵⁵). However, some attendees were resistant to the idea that CITs should be excluded based on peer-reviewed evidence alone, as their personal anecdotal evidence demonstrates the potential effectiveness of CITs in voice care. It was agreed that practitioners should potentially give more consideration to CITs during voice care planning. There was consensus that more research examining the acceptability and appropriateness of CITs within voice care is required, however, before including CITs routinely within practice.

Psychosocial Considerations

Impact on Mental Health

Attendees agreed that more consideration needs to be given to voice user mental health. There was consensus that experiencing a voice difficulty has a considerable impact on psychological wellbeing and yet mental health impacts are seldom addressed during voice care. Both EbE and practitioners spoke about the psychological needs of those presenting to voice care services, with EbE sharing their mental health journeys across the voice treatment course. Within this, there was particular focus on performance anxiety as it relates to voice and the psychological burden associated with performance anxiety. It was therefore agreed that practitioners working in voice healthcare need to be more confident and competent in considering mental health needs⁵⁶. It was agreed that practitioners should consider familiarizing themselves with principles in mental health and mental health first-aid and/or consider developing referral pathways to those with recognized qualifications in mental health.

Topics related to resilience and self-efficacy were referenced throughout. EbE reflected on the strength and resilience required to persist with their recovery journey, with reference to psychosocial adjustment processes. Attendees recognized the resilience this requires, particularly as livelihoods and careers often depend on regaining meaningful voice use. It was agreed that focusing on strengths (and less on problem-saturated narratives) can be a way to foster client resilience and feelings of self-efficacy.

Stigma and Barriers to Help-Seeking

Attendees agreed that there are several barriers to seeking help in voice care. The barriers identified were consistent with those cited in previous literature⁵⁷⁻⁵⁹. EbE spoke about perceived reduced access to suitable services, previous negative healthcare experiences, fear of stigma or shame, and uncertainty about the potential discovery of malignancy.

There was particular focus on exploring barriers to help-seeking experienced by those within the performing arts. Many attendees had experienced feelings of shame, guilt, or uncertainty related to

experiencing a voice difficulty within a performing arts context. There was recognition that a career in the performing arts is accompanied by expectations regarding perfectionism⁶⁰, physical conditioning⁶¹, and occupational uncertainty⁶², which can make it harder for individuals experiencing voice difficulties to feel able to seek help.

Service Design

In the UK (where the meeting was held), the British Voice Association maintains a directory of national health service voice clinics (http://www.britishvoiceassociation.org.uk/free_voice-clinics.htm), with some multidisciplinary voice teams also accessible privately. It is possible that existing services may not be sufficient to meet current demand, with EbE sharing their experience of long waiting times, mixed assessment and treatment suitability, and perhaps an over-reliance on pharmacological interventions. It was recognized that these issues are in part a consequence of wider pressures within the national health service and ongoing difficulties related to governance, resources, staffing, and the COVID-19 pandemic.

Attendees raised questions related to service design which may have implications for future practice. Attendees questioned the availability of voice specialist training routes for practitioners, particularly in speech and language therapy. There were also questions about how existing services can be developed to better account for individual differences in voice care and accessibility of multidisciplinary approaches. There was recognition that collaboration needs to be improved across disciplines and it was suggested that case coordination and multiagency liaison may be helpful.

Table 1. Recommendations

The recommendations provided here are underpinned by the key recommendation that experts-by-experience coproduce the planning, design, delivery, and evaluation of vocal health and voice care services

Assessment and Treatment

1. All clients should have access to multidisciplinary voice assessment. This should at a very minimum include input from speech and language therapists, laryngologists, voice coaches, and general medical practitioners (GPs), with consultation from other disciplines (psychology, occupational therapy, social work) if indicated and/or requested by the client.
2. Assessment should be occupation specific. Practitioners should have lived or acquired knowledge of the client's occupation, and this should be integrated within the assessment content. Assessment should explore the biopsychosocial factors associated with the client's occupation, if/when occupational voice use is indicated as part of the presenting problem.
3. Assessment and treatment should be underpinned by a working idiosyncratic biopsychosocial formulation. This should be developed collaboratively, with a focus on the client's goals and personal narrative.
4. Psychometric assessment and routine outcome measures should be embedded within voice assessment and treatment.

5. Practitioners should be mindful of iatrogenic effects and demonstrate commitment to person-centered and inclusive practice.
6. As well as direct assessment and intervention, there should be scope for practitioners to input towards cases indirectly (e.g., psychology case supervision with SLT to offer psychological perspective). Expecting direct contact between client and all professionals may not be feasible or appropriate.

Practitioner Approach

7. Speaking and singing principles should be explored. Practitioners should be made to feel confident exploring speaking and singing voice principles and should pursue specialist consultation or training if required.
8. There should be a shared commitment to developing and maintaining a good therapeutic relationship. Doing so requires the practitioner to demonstrate core process skills (e.g., empathy, active listening, consent and contracting).
9. Practitioners should follow the evidence-base for voice assessment and treatment, whilst also validating client perspectives on their care. This might include valuing and respecting client experiences of CITs, even if unconventional or counter to the practitioner's experience.

Psychosocial Considerations

10. Practitioners must recognize the psychological impacts of voice difficulties. Clients may experience mood and anxiety adjustments in response to their vocal performance. Consideration should be given to the role of performance anxiety and interactions with sense of self, identity, resilience, and self-efficacy.
11. Voice practitioners should not be expected to meet or address client mental health needs independently or directly. Practitioners do, however, have a responsibility to be aware of mental health support pathways and case-by-case consultation should be sought from mental health professionals when required. Practitioners wishing to develop their competencies in mental health support should look to access verified and evidence-based training in introductory mental health skills.
12. Barriers which restrict help-seeking and reinforce stigma must be addressed at personal, interpersonal, and systemic levels.

Service Design

13. There needs to be improved access to specialist voice services. This includes increasing the number of services available, as well as the scope of existing services.
 14. There should be more focus on voice specialist training routes and continued professional development.
 15. There should be greater involvement of multidisciplinary perspectives. This could include voice-specific care-coordination within a wider team i.e., a specialist practitioner who holds the case, provides consultation, and liaises with other practitioners and the client themselves, without being involved in the direct therapeutic work.
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Figure 1 about here

Figure 2 about here

DISCUSSION

Vocal Health Education hosted a meeting which was coproduced by EbE and practitioners. Attendees presented their personal and professional experience, as well as relevant academic literature, throughout the meeting. Importantly, to our knowledge, this is the first meeting of its kind within the vocal health field to have been coproduced in this way. Presentations and associated discussions covered themes related to assessment and treatment, practitioner approaches, psychosocial considerations, and service design. Themes were translated to recommendations (see Table 1) which were agreed by all participating EbE and practitioners. Potential future research directions stemming from the identified themes are presented in Table 2.

The consensus was that a biopsychosocial approach to voice care and vocal health should be prioritized. Attendees agreed that this requires appropriate voice assessment and treatment, following an idiosyncratic biopsychosocial formulation, developed collaboratively between practitioner and client. Practitioners must demonstrate awareness of conceptual and psychosocial considerations in voice work and advocate for improved service design and specificity (see Table 1). The recommendations given are consistent with guidelines given by the Royal College of Speech and Language Therapists in their position paper on working with individuals with voice disorders⁵, as well as practice suggestions given in previous research¹⁷⁻²¹.

Attendees identified that it is crucial that services involve those with lived experience in the planning, development, and implementation of services. We envision a fully integrated service in which EbE coproduce and co-construct the design, scope, and practice of voice care. It should be noted that this is in keeping with other areas of physical and mental health care but is, in our view, currently absent within voice healthcare. Barriers to including EbE in this process likely follow those cited above in relation to help-seeking, with potential additional barriers related to service culture, professional attitudes, and resources⁶³. Our recommendation is that involving EbE as stakeholders within voice care decision making might lead to better or more fulfilling outcomes for both practitioners and clients.

This paper has provided recommendations for improving practice in voice care based on EbE and practitioner consensus. While we have offered thorough and practical recommendations, there are some limitations within our study design which limit the strength of the presented findings. First, the meeting was based in the UK and thus the presented themes and recommendations may not be generalizable internationally. Second, the listed recommendations only represent the perspectives of the meeting attendees. This means that consensus should be surveyed and reviewed at other voice healthcare meetings to ensure acceptability and appropriateness. It is of course possible that voice specialties which were not represented at the meeting (e.g., nursing) would have a different perspective and thus the recommendations presented here may not be fully representative of professional approaches. Third, some of the recommendations we have made might require changes to service design and provision. It is important to note that no national health service commissioners

or senior leaders were present at the meeting and so we are unable to comment on the financial or logistical ramifications of the proposed recommendations within public health services.

Recommendations should therefore be considered and evaluated by those within national health service leadership before being accepted as conclusive. Fourth, the gathering of consensus did not follow a formal framework (e.g., Delphi method), perhaps limiting the strength of the presented recommendations. Fifth, it was beyond the scope of our research to evaluate any of the qualitative data gathered during the meeting via formal qualitative analysis and thus we encourage future studies to use more formal data gathering and analysis methods. Finally, it was not possible to explore how the recommendations presented here may vary depending on client individual differences (e.g., age; gender; diagnosis; clinical history) and thus more work is needed to understand how these identity characteristics inform experience of vocal healthcare, with more effort towards inclusion and representation within professional practice. Future research should look to address these limitations.

Table 2. Potential future research directions

Future Research Directions

1. Explore the utility of narrative ideas related to externalization and strengths-based approaches in voice care.
 2. Further investigate the use of - and overlaps between - speech and singing principles in voice therapy.
 3. Consider how voice care practitioners and clients form therapeutic relationships. This could include studies of how to define and characterize therapeutic relationships in voice care, as well as their influence on outcomes.
 4. Explore in more detail the care experiences of those with lived experience of voice difficulties. This could include analysis of responses to care, as well as perceptions of practitioner approach. Perceptions of the suitability and effectiveness of alternative treatment routes (for example CITs) could also be explored.
 5. Investigate practitioner competence and confidence in responding to client mental health needs. This could include service audit(s) of practitioner mental health training, studies of practitioner perceptions of their current practice, and/or consideration of whether formal mental health training should be a requirement for voice care practitioners.
 6. Explore in more detail barriers to help-seeking in voice care. This should include consideration of personal, interpersonal, and systemic barriers.
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REFLECTION

Attendee reflections were taken after the meeting and once the manuscript had been written and read by the authors. The reflections are presented in the supplemental material. These reflections highlight how it felt for EbE and practitioners to be involved in the consensus process, and what they hope it may achieve. This is with the aim of demonstrating the value of coproduction between EbE and practitioners in voice healthcare.

CONCLUSION

This paper has presented EbE and practitioner consensus arising from a multidisciplinary vocal health meeting hosted in the UK. The recommendations offered inform voice care assessment, formulation, and treatment and, if followed, are expected to have a positive impact on client experience of services. There is a requirement for more research investigating appropriateness and effectiveness of existing voice care services, with an increased focus on including the perspectives of those with lived experience of voice difficulties. The themes and recommendations presented throughout this consensus will hopefully inspire a greater involvement of EbE in voice care services. We see this as an essential step in providing future-facing and effective voice care.

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Figure 1. Voice Care Matrix

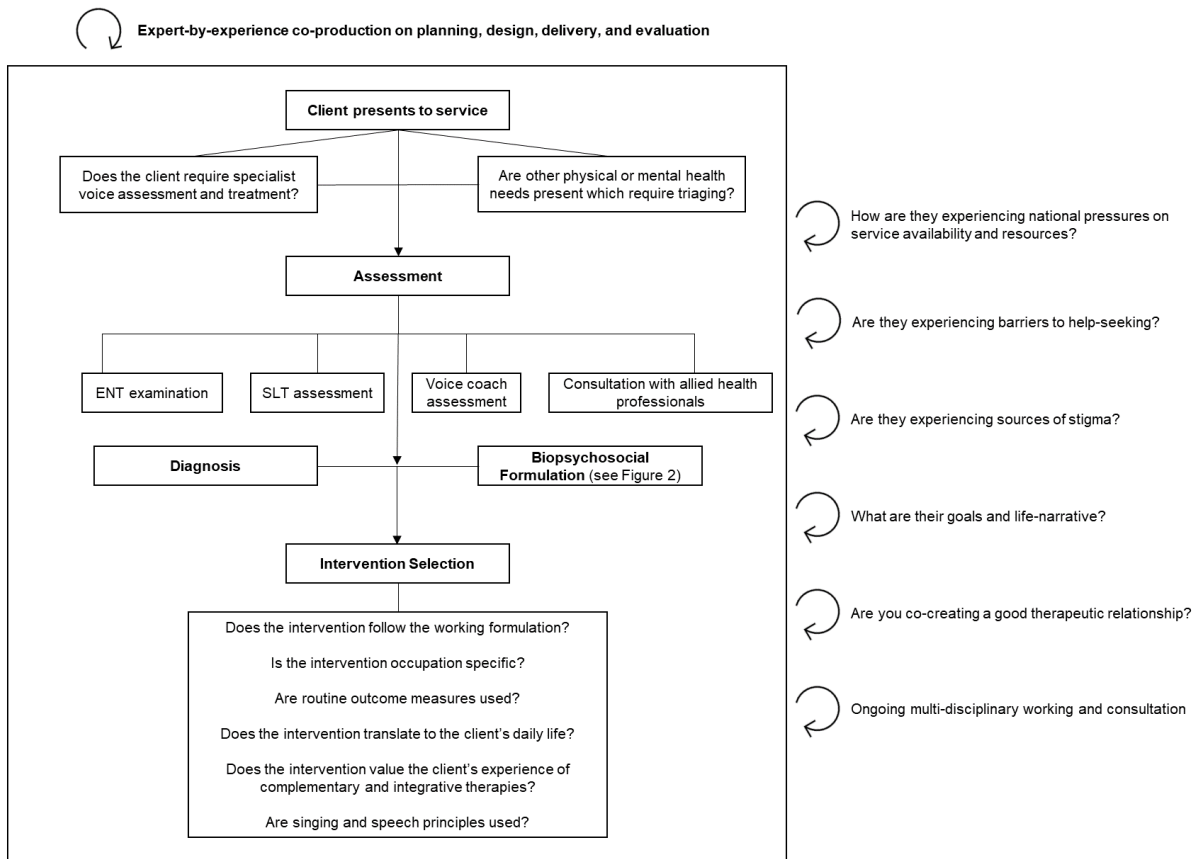


Figure 2. Biopsychosocial Formulation Framework

