

Working Together to Find a Voice: Recommendations for Voice Healthcare Based on Expert-By-Experience and Practitioner Consensus

*[†]Lydia Flock, ^{†,‡}Stephen R. King, ^{†,‡}Jenevora Williams, [§]Emma Finlay, ^{||}Hannah Smikle, [§]Monica Benito, [§]Francesca Benton-Stage, [¶]Jenna Brown, [¶]Abigail J. Mann-Daraz, ^{†,‡}Lydia Hart, ^{**}Keesha Mclean, ^{††}Zofia Prucnal, ^{††}Louisa Barry, ^{§§}Rachel Lynes, ^{||}Mel Toy, ^{†,¶¶}Kate Valentine, ^{##}Sam Slattery, and ^{***}Luke Aldridge-Waddon, ^{****}Oxford, ^{††§§§§}|| London, ^{||}Stockport, [¶]Suffolk, [#]Berkshire, ^{**}Cairns, ^{††}Warsaw, ^{‡‡}and ^{¶¶}Seaford, UK, and ^{##}Turks, Islands

Summary: 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 nonclinical 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 nonclinical 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 flexibility,¹ spanning functional and organic diagnostic categories.² 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 symptoms,¹ with ever-increasing rates of referral for specialist support.⁸ 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 times,¹⁴

Accepted for publication February 20, 2023.

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

From the *Vocal Manual Therapy, Oxford Vocal Massage, Oxford, UK; †Voice Care Centre, Voice Care Centre, London, UK; ‡Vocal Health Education, Vocal Health Education, London, UK; §Independent Researcher, VHE Meeting, London, UK; ||Vocal Coaching, Hannah Smikle-Vocal Performance Coaching, Stockport, UK; ¶Voice Study Centre, Voice Study Centre, Suffolk, UK; #Speech and Language Therapy, Frimley Health NHS Foundation Trust, Berkshire, UK; **Cairns Voice Studio and Cairns Voice Care, Cairns Voice Studio and Cairns Voice Care, Cairns, Australia; ††Vocal Coaching, Warsaw Vocal Studio, Warsaw, Poland; ‡‡Voice Coaching, Louisa Barry—Voice, London, UK; §§The Sing Space, The Sing Space, London, UK; |||Mel Toy Music, Mel Toy Music, London, UK; ¶¶Valentine Voice Care, Valentine Voice Care, Seaford/Glasgow/London, UK; ###Grace Bay Medical, Grace Bay Medical, Grace Bay, Turks and Caicos Islands; and the ****Oxford Institute of Clinical Psychology Training and Research, Oxford Health NHS Foundation Trust, Warneford Hospital, Warneford Lane, Oxford, UK.

Address correspondence and reprint requests to Luke Aldridge-Waddon E-mail: luke.aldridge-waddon@hmc.ox.ac.uk

Journal of Voice, Vol. ■■■, No. ■■■, pp. ■■■–■■■
0892-1997

© 2023 The Voice Foundation. Published by Elsevier Inc. All rights reserved.
<https://doi.org/10.1016/j.jvoice.2023.02.023>

complicated pathways towards voice care,³ and mixed evidence and opinions regarding treatment efficacy,^{15,16} can sometimes 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 (ie, 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 clinics,¹⁴ with SLT-led services reporting positive treatment outcomes and low re-referral rates.²⁴ 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 studies^{26–28} 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 (eg, lived experience perspectives on support following laryngectomy²⁹), with recent consensus statements regarding best practice in physical and mental health^{30–33} 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. Voice practitioners working within the national health service and the private sector were present at the meeting. Five attendees are currently in senior leadership roles within national health service and/or private sector multidisciplinary voice centers, such as the Voice Care Centre. 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.

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](#). Potential future research directions linked to the recommendations are presented in [Table 2](#). Themes, recommendations, and research directions, 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 (ie, 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 workload.^{34–36} We acknowledge that most practitioners are acutely aware of their client's

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 (eg, 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 (eg, empathy, active listening, consent and contracting).
9. Practitioners should follow the evidence-base for voice assessment and treatment, while 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 ie, 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.

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

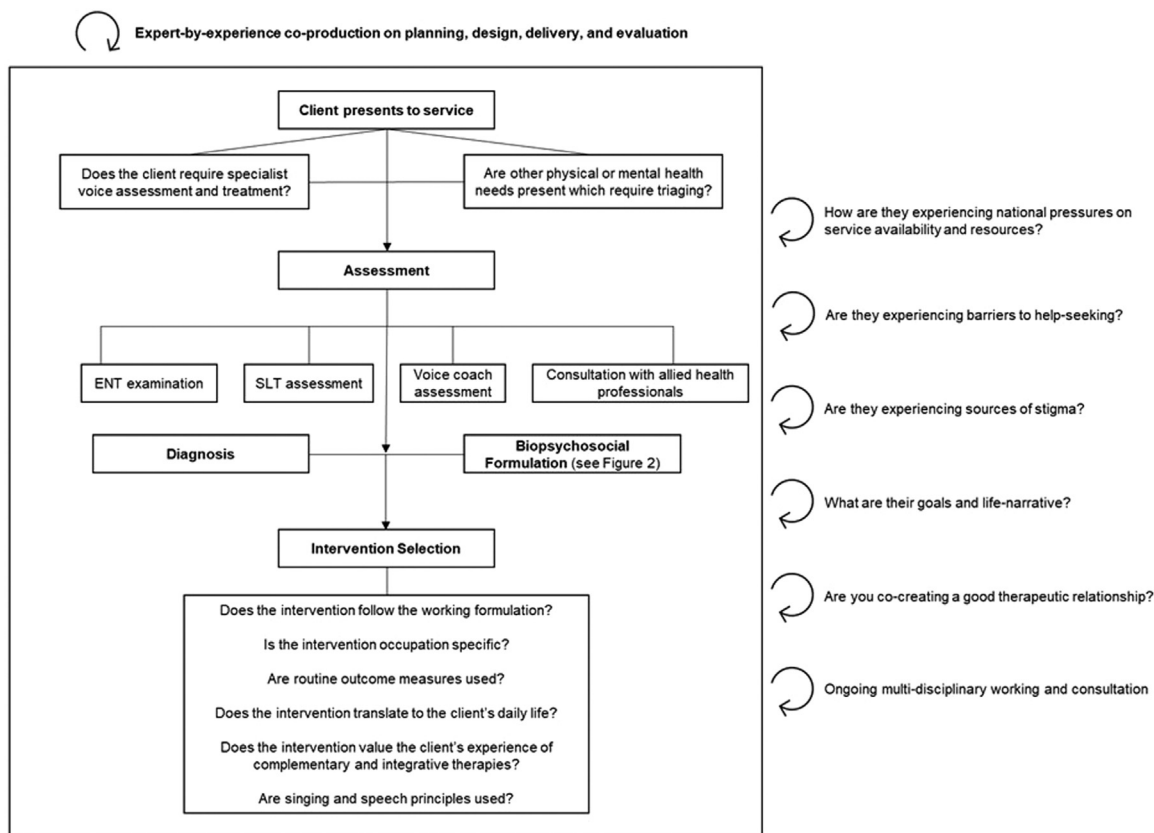


FIGURE 1. Voice care matrix.

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 index.⁴¹ 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 (ie, voice difficulties in the absence of organic pathology) emphasized the importance of compassionate and nonjudgmental 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 (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 timepressures 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 health,⁴³ 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

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.

unclear,⁴⁴ 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

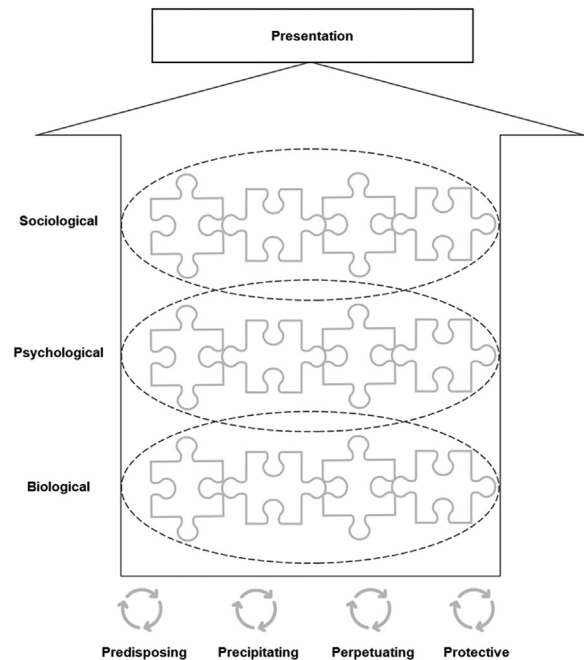


FIGURE 2. Biopsychosocial formulation framework.

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 (eg, 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 domains of the voice.⁴⁹ 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 some 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 skills.⁵² 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. 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 needs.⁵⁶ 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 literature.^{57–59} 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 perfectionism,⁶⁰ physical conditioning,⁶¹ and occupational uncertainty,⁶² 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 SLT. There were also questions about how existing services can be developed to better account for individual differences in voice care and the 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.

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 disorders,⁵ as well as practice suggestions given in previous research.^{17–21}

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 resources.⁶³ 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 (eg, 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 governors 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 governance before being accepted as conclusive. Fourth, the gathering of consensus did not follow a formal framework (eg, 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 (eg, 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.

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.

ETHICS STATEMENT

Not applicable (no ethical approval required).

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

DECLARATION OF COMPETING INTEREST

The meeting was hosted by Vocal Health Education (VHE), a not-for-profit organization founded and run by two of the manuscript authors (SK and JW). LF and LB have received honoraria from VHE within the last three years for the completion of administrative responsibilities. JB and LH have received honoraria from VHE within the last three years for the completion of teaching responsibilities. All other authors declare no competing interests.

ACKNOWLEDGMENTS

We are grateful for the contributions of Conor O'Boyle and Beckie Tunnicliffe. We would also like to thank Sally Wood who helped to coordinate the meeting and provided administrative support throughout the preparation of this manuscript.

SUPPLEMENTARY DATA

Supplementary data related to this article can be found online at [doi:10.1016/j.jvoice.2023.02.023](https://doi.org/10.1016/j.jvoice.2023.02.023).

REFERENCES

- Merrill RM, Roy N, Lowe J. Voice-related symptoms and their effects on quality of life. *Ann Otol Rhinol Laryngol*. 2013;122:404–411. <https://doi.org/10.1177/000348941312200610>.
- Baker J, Ben-Tovim DI, Butcher A, et al. Development of a modified diagnostic classification system for voice disorders with inter-rater reliability study. *Logop Phoniatr Vocology*. 2007;32:99–112. <https://doi.org/10.1080/14015430701431192>.
- Phillips PS, Carlson E, Chevretton EB. Does a specialist voice clinic change ENT clinic diagnosis? *Logop Phoniatr Vocology*. 2005;30:90–93. <https://doi.org/10.1080/14015430500233286>.
- Mathieson L. *Greene and Mathieson's the Voice and Its Disorders*. 6th ed. London: John Wiley & Sons; 2013.
- Position statement: speech and language therapists working with individuals with voice disorders. Royal College of Speech and Language Therapists. 2019. Published online. <https://www.rcslt.org/wp-content/uploads/media/docs/clinical-guidance/voice-position-statement.pdf>.
- Heman-Ackah YD, Sataloff RT, Hawkshaw MJ. Who takes care of voice problems? A guide to voice care providers. *J Sing*. 2002;59:139–146.
- Payten CL, Chiapello G, Weir KA, et al. Frameworks, terminology and definitions used for the classification of voice disorders: a scoping review. *J Voice*. 2022. <https://doi.org/10.1016/j.jvoice.2022.02.009>. In Press.
- Benninger MS, Holy CE, Bryson PC, et al. Prevalence and occupation of patients presenting with dysphonia in the United States. *J Voice*. 2017;31:594–600. <https://doi.org/10.1016/j.jvoice.2017.01.011>.
- Lechien JR, Barillari MR, De Marrez LG, et al. Dysphonia in COVID-19 patients: direct or indirect symptom? *Am J Otolaryngol*. 2022;43:103246. <https://doi.org/10.1016/j.amjoto.2021.103246>.
- Tohidast SA, Mansuri B, Memarian M, et al. Voice quality and vocal tract discomfort symptoms in patients with COVID-19. *J Voice*. 2021;43:103246. <https://doi.org/10.1016/j.jvoice.2021.09.039>.
- Bertelsen C, Zhou S, Hapner ER, et al. Sociodemographic characteristics and treatment response among aging adults with voice disorders in the United States. *JAMA Otolaryngol Head Neck Surg*. 2018;144:719–726. <https://doi.org/10.1001/jamaoto.2018.0980>.
- Golub JS, Chen P-H, Otto KJ, et al. Prevalence of perceived dysphonia in a geriatric population. *J Am Geriatr Soc*. 2006;54:1736–1739. <https://doi.org/10.1111/j.1532-5415.2006.00915.x>.
- Turley R, Cohen S. Impact of voice and swallowing problems in the elderly. *Otolaryngol Head Neck Surg*. 2009;140:33–36. <https://doi.org/10.1016/j.otohns.2008.10.010>.
- Vaghela HM, Fergie N, Slade S, et al. Speech therapist led voice clinic: which patients may be suitable? *Logop Phoniatr Vocology*. 2005;30:85–90. <https://doi.org/10.1080/14015430510006686>.
- Carding P, Bos-Clark M, Fu S, et al. Evaluating the efficacy of voice therapy for functional, organic and neurological voice disorders. *Clin Otolaryngol*. 2017;42:201–217. <https://doi.org/10.1111/coa.12765>.
- Chan AK, McCabe P, Madill CJ. The implementation of evidence-based practice in the management of adults with functional voice disorders: a national survey of speech-language pathologists. *Int J Speech Lang Pathol*. 2013;15:334–344. <https://doi.org/10.3109/17549507.2013.783110>.
- Umeno H, Hyodo M, Haji T, et al. A summary of the clinical practice guideline for the diagnosis and management of voice disorders, 2018 in Japan. *Auris Nasus Larynx*. 2020;47:7–17. <https://doi.org/10.1016/j.anl.2019.09.004>.
- Ludlow CL, Domangue R, Sharma D, et al. Consensus-based attributes for identifying patients with spasmodic dysphonia and other voice disorders. *JAMA Otolaryngol Head Neck Surg*. 2018;144:657–665. <https://doi.org/10.1001/jamaoto.2018.0644>.
- Barkmeier-Kraemer JM, Patel RR. The next 10 years in voice evaluation and treatment. *Semin Speech Lang*. 2016;37:158–165. <https://doi.org/10.1055/s-0036-1583547>.
- Martin S. *Working with Voice Disorders: Theory and Practice*. Abingdon: Routledge/Taylor & Francis Group; 2017.
- Stachler RJ, Francis DO, Schwartz SR, et al. *Clinical Practice Guideline*. 158. Alexandria VA: Hoarseness (Dysphonia) (Update); 2018. <https://doi.org/10.1177/0194599817751030>.
- Watters C, Miller B, Kelly M, et al. Virtual voice clinics in the COVID-19 era: have they been helpful? *Eur Arch Otorhinolaryngol*. 2021;278:4113–4118. <https://doi.org/10.1007/s00405-021-06643-6>.
- Zughni LA, Gillespie AI, Hatcher JL, et al. Telemedicine and the interdisciplinary clinic model: during the COVID-19 pandemic and beyond. *Otolaryngol Head Neck Surg*. 2020;163:673–675. <https://doi.org/10.1177/0194599820932167>.
- Schwarz M, Ward EC, Seabrook M, et al. Outcomes from an extended scope of practice speech-language pathology service for low risk ENT outpatients: a 5-year service review. *Int J Speech Lang Pathol*. 2022;24:3–11. <https://doi.org/10.1080/17549507.2021.1916592>.
- Iwarsson J. Reflections on clinical expertise and silent know-how in voice therapy. *Logop Phoniatr Vocology*. 2015;40:66–71. <https://doi.org/10.3109/14015439.2014.949302>.
- Baylor CR, Yorkston KM, Eadie TL. The consequences of spasmodic dysphonia on communication-related quality of life: a qualitative study of the insider's experiences. *J Commun Disord*. 2005;38:395–419. <https://doi.org/10.1016/j.jcomdis.2005.03.003>.
- Etter NM, Stemple JC, Howell DM. Defining the lived experience of older adults with voice disorders. *J Voice*. 2013;27:61–67. <https://doi.org/10.1016/j.jvoice.2012.07.002>.

28. Lepock E. No space to sing: a narrative inquiry into the experiences of classical singers with primary muscle tension dysphonia. *Doctoral dissertation*. The University of Western Ontario; 2019.
29. Bickford JM, Coveney J, Baker J, et al. Support following total laryngectomy: exploring the concept from different perspectives. *Eur J Cancer Care (Engl)*. 2018;27:1–10. <https://doi.org/10.1111/ecc.12848>.
30. Albury C, Strain WD, Le Brocq S, et al. The importance of language in engagement between health-care professionals and people living with obesity: a joint consensus statement. *Lancet Diabetes Endocrinol*. 2020;8:447–455. [https://doi.org/10.1016/S2213-8587\(20\)30102-9](https://doi.org/10.1016/S2213-8587(20)30102-9).
31. Nock MK, Kleiman EM, Abraham M, et al. Consensus statement on ethical & safety practices for conducting digital monitoring studies with people at risk of suicide and related behaviors. *Psychiatr Res Clin Pract*. 2021;3:57–66. <https://doi.org/10.1176/appi.prcp.20200029>.
32. Richards KL, Woolrych I, Allen KL, et al. A Delphi study to explore clinician and lived experience perspectives on setting priorities in eating disorder services. *BMC Health Serv Res*. 2022;22:1–15. <https://doi.org/10.1186/s12913-022-08170-4>.
33. Filia K, Jackson H, Cotton S, et al. Understanding what it means to be socially included for people with a lived experience of mental illness. *Int J Soc Psychiatry*. 2019;65:413–424. <https://doi.org/10.1177/0020764019852657>.
34. Lyberg-Åhländer V, Rydell R, Fredlund P, et al. Prevalence of voice disorders in the general population, based on the Stockholm Public Health Cohort. *J Voice*. 2019;33:900–905. <https://doi.org/10.1016/j.jvoice.2018.07.007>.
35. Vilkman E. Voice problems at work: a challenge for occupational safety and health arrangement. *Folia Phoniatr Logop*. 2000;52:120–125. <https://doi.org/10.1159/000021519>.
36. Williams NR. Occupational groups at risk of voice disorders: a review of the literature. *Occup Med (Chic Ill)*. 2003;53:456–460. <https://doi.org/10.1093/occmed/kqg113>.
37. Schneider SL, Sataloff RT. Voice therapy for the professional voice. *Otolaryngol Clin North Am*. 2007;40:1133–1149. <https://doi.org/10.1016/j.otc.2007.05.013>.
38. Jacobson BH, Johnson A, Grywalski C, et al. The voice handicap index (VHI): development and validation. Jacobson Llewellyn-Thomas, Newman, Newman, Nunnally, Smith, Stemple, Ventry K, eds. *Am J Speech-Language Pathol*. 1997;6:66–70. <https://doi.org/10.1044/1058-0360.0603.66>.
39. Hogikyan ND, Sethuraman G. Validation of an instrument to measure voice-related quality of life (V-RQOL). *J Voice*. 1999;13:557–569. [https://doi.org/10.1016/S0892-1997\(99\)80010-1](https://doi.org/10.1016/S0892-1997(99)80010-1).
40. Phyland DJ, Pallant JF, Benninger MS, et al. Development and preliminary validation of the EASE: a tool to measure perceived singing voice function. *J Voice*. 2013;27:454–462. <https://doi.org/10.1016/j.jvoice.2013.01.019>.
41. Cohen SM, Jacobson BH, Garrett CG, et al. Creation and validation of the singing voice handicap index. *Ann Otol Rhinol Laryngol*. 2007;116:402–406. <https://doi.org/10.1177/000348940711600602>.
42. Payten CL, Chiapello G, Weir KA, et al. Terminology and frameworks used for the classification of voice disorders: a scoping review protocol. *JBI Evid Synth*. 2021;19:454–462. <https://doi.org/10.11124/JBIES-20-00066>.
43. Van Stan JH, Roy N, Awan S, et al. A taxonomy of voice therapy. *Am J Speech-Language Pathol*. 2015;24:101–125.
44. Desjardins M, Halstead L, Cooke M, et al. A systematic review of voice therapy: what “effectiveness” really implies. *J Voice*. 2017;31:392.e13–392.e32. <https://doi.org/10.1016/j.jvoice.2016.10.002>.
45. Strong T. Externalising questions: a micro-analytic look at their use in narrative therapy. *Int J Narrat Ther Community Work*. 2008;3: 59–71.
46. LeBorgne WD, Donahue E. The use of singing as a therapeutic modality within the context of voice therapy. *Perspect Voice Voice Disord*. 2014;24:94–97. <https://doi.org/10.1044/vvd24.2.94>.
47. Rinta T, Welch G. Should singing activities be included in speech and voice therapy for prepubertal children? *J Voice*. 2008;22:100–112.. Available at: <https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,uid&db=cin20&AN=105892742&authtype=shib&site=ehost-live&authtype=ip,uid>.
48. Sielska-Badurek E, Osuch-Wójcikiewicz E, Sobol M, et al. Combined functional voice therapy in singers with muscle tension dysphonia in singing. *J Voice*. 2017;31:509.e23–509.e31. <https://doi.org/10.1016/j.jvoice.2016.10.026>.
49. Gilman M, Nix J, Hapner E. The speech pathologist, the singing teacher, and the singing voice specialist: where’s the line? *J Sing*. 2010;67:171.
50. McLeod M. The caring physician: a journey in self-exploration and self-care. *Am J Gastroenterol*. 2003;98:2135–2138. [https://doi.org/10.1016/s0002-9270\(03\)00752-4](https://doi.org/10.1016/s0002-9270(03)00752-4).
51. Posluns K, Gall TL. Dear mental health practitioners, take care of yourselves: a literature review on self-care. *Int J Adv Couns*. 2020;42:1–20. <https://doi.org/10.1007/s10447-019-09382-w>.
52. Edvardsson D. Notes on person-centred care: what it is and what it is not. *Nord J Nurs Res*. 2015;35:65–66. <https://doi.org/10.1177/0107408315582296>.
53. Flock L, King S. Vocal manual therapy: the consent EQUATION (and why you should care about it). *Voice Speech Rev*. 2022:1–10. <https://doi.org/10.1080/23268263.2022.2112644>. Published online.
54. Surow JB, Lovetri J. “Alternative medical therapy” use among singers: prevalence and implications for the medical care of the singer. *J Voice*. 2000;14:398–409. [https://doi.org/10.1016/s0892-1997\(00\)80085-5](https://doi.org/10.1016/s0892-1997(00)80085-5).
55. Dewan K, Lopez V, Jamal N. Complementary and integrative medicine and the voice. *Otolaryngol Clin North Am*. 2022;55:1007–1016.
56. Flock L, Aldridge-Waddon L. The singing studio and mental health: giving a voice to singing teacher mental health training and development [unpublished manuscript].
57. Cohen SM. Self-reported impact of dysphonia in a primary care population: an epidemiological study. *Laryngoscope*. 2010;120:2022–2032. <https://doi.org/10.1002/lary.21058>.
58. Da Costa V, Prada E, Roberts A, et al. Voice disorders in primary school teachers and barriers to care. *J Voice*. 2012;26:69–76. <https://doi.org/10.1016/j.jvoice.2010.09.001>.
59. Gilman M, Merati AL, Klein AM, et al. Performer’s attitudes toward seeking health care for voice issues: understanding the barriers. *J Voice*. 2009;23:225–228. <https://doi.org/10.1016/j.jvoice.2007.08.003>.
60. Hall HK, Hill AP. Perfectionism, dysfunctional achievement striving and burnout in aspiring athletes: the motivational implications for performing artists. *Theatr Danc Perform Train*. 2012;3:216–228. <https://doi.org/10.1080/19443927.2012.693534>.
61. Quarrier NF. Performing arts medicine: the musical athlete. *J Orthop Sports Phys Ther*. 1993;17:90–95. <https://doi.org/10.2519/jospt.1993.17.2.90>.
62. Bennett D, Bridgstock R. The urgent need for career preview: student expectations and graduate realities in music and dance. *Int J Music Educ*. 2015;33:263–277. <https://doi.org/10.1177/0255761414558653>.
63. Social Care Institute for Excellence. Breaking Down the Barriers to Co-Production. London, UK; 2019.