Loyola Marymount University

Advancing Equity in Cancer Clinical Trial Participation

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Learning objectives

By the end of this presentation, you will be able to:

1) Describe: At least **three inequities** affecting racially and ethnically minoritized populations, people facing socioeconomic disadvantage, rural populations, and/or people with co-occurring mental health conditions.

2) Identify: At least **three barriers** to equitable access to and participation in cancer clinical trials.

3) Identify: At least **three strategies** to promote equitable access to and participation in cancer clinical trials.

Why equitable participation matters

Who participates shapes the evidence that informs cancer care.

People deserve a meaningful opportunity to consider research participation.

Individual interest matters. So do the systems that enable participation.

Oyer et al., 2022

Four domains of inequities in clinical trial participation

Race and ethnicity

Concern: Underrepresentation and unequal opportunities

Socioeconomic disadvantage

Concern: Financial constraints and time burdens

Rural residence

Concern: Distance and limited local trial availability

Co-occurring mental health conditions

Concern: Restrictive eligibility and inadequate support

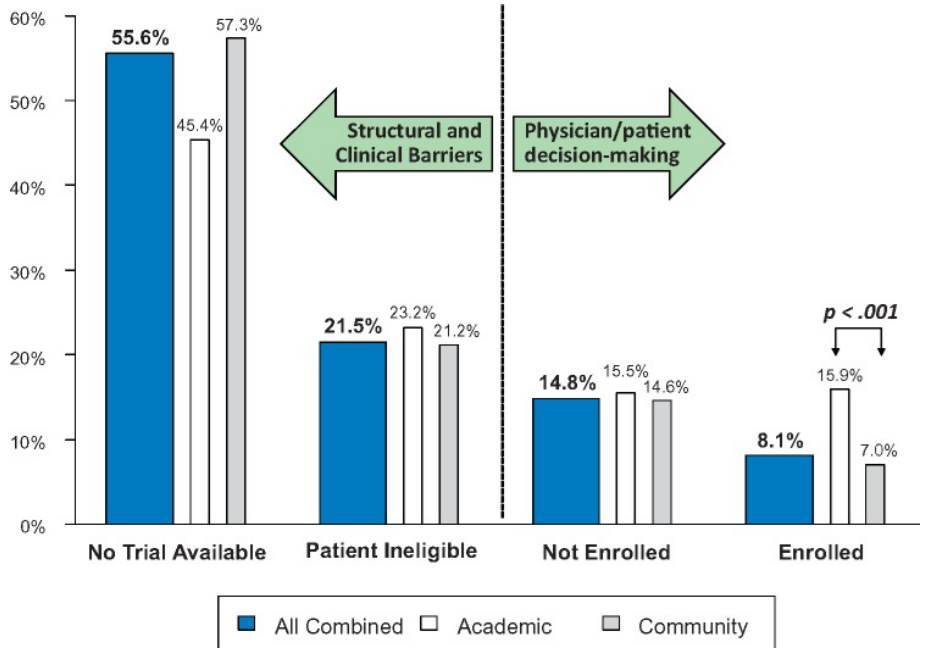
Domains can overlap. The concerns, barriers, and recommendations also differ.

Oyer et al., 2022; Unger et al., 2016, 2025; Irwin et al., 2019

Barriers arise before a decision is possible

Trial availability and eligibility

are prominent barriers to participation.



Unger et al., 2019, Figure 4

The pathway to meaningful clinical trial participation

Access	*Is a relevant trial available and reachable?*
Opportunity	*Is the person screened, considered eligible, and offered participation?*
Respect and trust	*Are their language, experiences, values, and concerns understood?*
Choice and support	*Can they make an informed decision and sustain participation?*

Unger et al., 2019; Oyer et al., 2022; Guerra et al., 2023

When a trial is offered, interest is high!

More than 50%

agreed to participate
when offered a cancer trial.

Participation was comparable across Black, Hispanic/Latinx, Asian, and White patients in studies providing these comparisons.

Enrollment disparities alone do not indicate differences in interest or willingness.

Unger et al., 2021

Suspicion, mistrust, and willingness can coexist

Our student research

Black adults with a cancer history reported greater trial suspicion than non-Hispanic White adults, yet similar rates of interest in clinical trials.

Preliminary findings

PRRISM Research Lab
Psychosocial Risk & Resilience in Stress & Medicine

Published evidence

Black participants reported greater medical mistrust and lower trial knowledge, but similar intentions to participate if offered.

Discuss concerns openly without assuming these concerns indicate a lack of interest.

Castro & Williamson, in preparation; Hoadley et al., 2024

Understand what concerns are grounded in

Historical and contemporary experiences

Example: Focus groups with Black women described how historical research abuses, mistreatment, and being dismissed were relevant to their views of healthcare and research.

Cultural and institutional context

Example: Recruitment work with Chinese immigrants identified mistrust, scam concerns, family involvement, and language needs.

Acknowledge these experiences directly, openly, and with understanding of context.

Riggan et al., 2023; Lui et al., 2026; Hoadley et al., 2024

Make trial opportunities consistent

Becoming Aware of Assumptions

Teams may make assumptions about someone's interest, resources, or the burden participation would create. These assumptions can shape how clinical and research staff discuss clinical trials with people.

Establishing Consistent Processes

Screen and discuss trials consistently with people who may be eligible. **Ask** about individual preferences for communication and needs for support before deciding what is feasible.

Niranjan et al., 2020; Oyer et al., 2022

Cultural competence and cultural humility

Cultural competence

Knowledge and skills for culturally responsive communication and care.

Cultural humility

Ongoing self-reflection, reciprocal learning, and attention to power imbalances.

Individual

Examine assumptions in recruitment decisions.

Interpersonal

Learn each person's experiences and priorities.

Collective

Share influence over research and practice.

Abe, 2020; Tervalon & Murray-García, 1998

Language access goes beyond translation

Problems of language accessibility

In one study…

9 of 17

calls to cancer centers required **three calls** to reach a staff member who spoke Spanish.

Support the whole process of communication by ensuring:

Plain language and culturally relevant explanations in educational materials

Qualified interpreters and incorporating checks of understanding

Gathering preferences for sharing information and involving family

Sandoval et al., 2023; Ezeoke et al., 2023; Oyer et al., 2022

Strengthening Bidirectional Dialogue with Communities

Invite concerns	Make space to discuss historical and contemporary experiences and priorities for participation.
Change practice	Partner on recruitment, consent, language support, scheduling, or financial assistance.
Report back	Explain what changed, what remains unresolved, and whether the response meets the original concern.

Kaljee et al., 2025; Oyer et al., 2022

Community partnership in practice

Contents lists available at ScienceDirect

Preventive Medicine Reports

journal homepage: www.elsevier.com/locate/pmedr

What matters to us: Bridging research and accurate information through dialogue (BRAID) to build community trust and cultivate vaccine confidence

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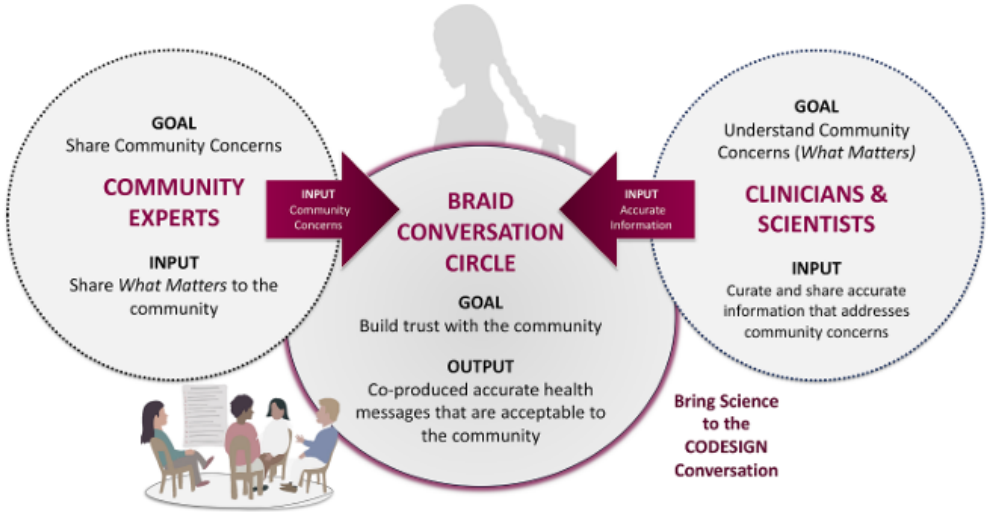


Fig. 1. The BRAID *(Bridging Research, Accurate Information and Dialogue)* Model.

Participation can carry substantial costs

People with lower incomes face greater barriers to trial participation.

Direct expenses

Transportation, parking, lodging, and additional visits.

Time and responsibilities

Time away from paid work and caregiving arrangements.

Chen et al., 2025; Nipp et al., 2016; Unger et al., 2016

Plan and fund participation support

Strategy

Identify institutional resources to subsidize direct and hidden costs of participation.

Example: Cancer Care Equity Program

Travel and lodging assistance, navigation, and outreach were associated with increased trial enrollment.

Program evaluation of a nonrandomized study. Components were not evaluated individually.

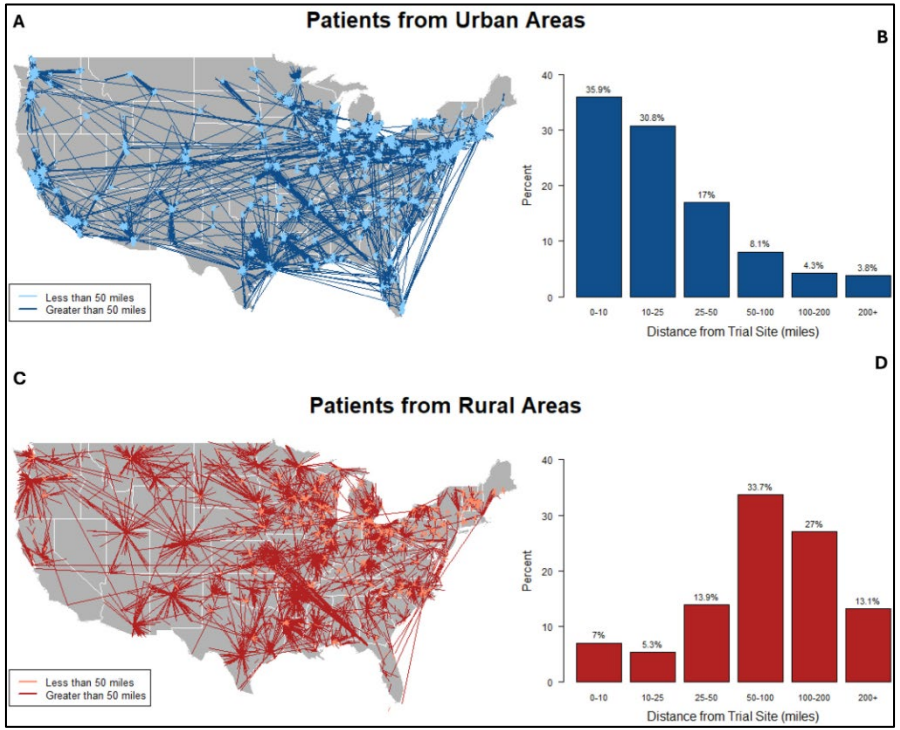
Nipp et al., 2016; Chen et al., 2025; Unger et al., 2016

Rural participation can require more travel

74%

of rural enrollees lived more than 50 miles from the trial site.

These data describe people who *enrolled*.



Unger et al., 2025, Figure 2

Bring feasible study activities closer to home

Local and remote	Use local testing, telehealth, and remote symptom monitoring when clinically appropriate and protocol-permitted.
Usable access	Plan connectivity, technical assistance, local coordination, and alternatives; support necessary travel.
Local capacity	Build partnerships and community research capacity so more people can learn about and join trials.

Unger et al., 2025

Broad exclusions can restrict equitable access to trials

Broad or discretionary exclusions can restrict trial opportunities, particularly for people with co-occurring mental health conditions (e.g., bipolar disorder)

Psychiatric diagnosis alone does not establish capacity, adherence, or trial-specific risk.

Assess individual circumstances, consent, safety, and available support.

Agaronnik et al., 2025; Irwin et al., 2019

Make individualized support part of participation

Understanding	Plain language discussion, teach back techniques, and additional time for information sharing process.
Care coordination	Communicate with treating clinicians, with the person's permission. Establish whether person is adequately managing symptoms of co-occurring MH diagnosis.
Study demands	Offer reminders, flexible scheduling, and a consistent contact, which can help address common barriers.

Irwin et al., 2019

Bridge: pilot study designed around care needs for people diagnosed with cancer and serious mental illness

A 12-week care-delivery pilot

Adults with a new cancer diagnosis and serious mental illness

Integrated psychiatric care, cancer care, and case management

Supported consent and flexible assessments

30 of 33

eligible patients enrolled

25 of 29 completed assessments at every study timepoint.

Irwin et al., 2019, The Oncologist

Reflect on decisions and shift practices

Recurring team learning

Use recruitment case studies to examine assumptions about interest, resources, and follow-through.

Practice conversations about participant preferences and needed support.

ASCO/ACCC pilot study

Online learning and facilitated discussion were feasible.

Knowledge gains were sustained at six weeks.

Knowledge gains do not establish changes in behavior or enrollment equity.

Barrett et al., 2023; Oyer et al., 2022

Use data from clinical trial recruitment to change practice

Track the pathway

Screening → eligibility → offers/discussion → enrollment

Identify why opportunities were missed.

Assign responsibility, change procedures, and reassess.

82%

of 62 research sites identified improvement opportunities after reviewing data and practices in ASCO/ACCC pilot study.

Only 2 sites systematically tracked metrics of the full recruitment pathway by race and ethnicity.

Guerra et al., 2023; Oyer et al., 2022

Diversifying research teams, training, and leadership

Equitable training, mentorship, and leadership are institutional responsibilities that have potential to:

Broaden knowledge	Bring cultural and linguistic expertise and community relationships into study design.
Build relationships	Pair representation with respectful communication and institutional responsiveness.
Shape practice	Give diverse perspectives and meaningful roles in decision-making.

Oyer et al., 2022; Alsan et al., 2025; Price et al., 2025

Mindful Self-Compassion for Lung Cancer

A pilot randomized trial of a group intervention to address lung cancer stigma.

Patient, clinician, and researcher perspectives shaped the program:

Study procedures

Shortened sessions to 90 minutes; added choices for breathing and movement practices.

Study communication

Adapted language to acknowledge stigma and reflect lung cancer experiences.

Williamson et al., 2025, 2026; NCT06191939

Representation, relationships, and reflection

Team and materials	A racially and ethnically diverse team and culturally tailored recruitment materials, with focused outreach to Black lung cancer survivors *(through an NCI-funded* research supplement to promote diversity)*
Ongoing reflection	Cultural humility training and weekly supervision to discuss concerns and adapt study delivery.
Human connection and Trust building	A video call and welcome conversation with the study team; the PI met every participant individually to answer questions and support informed participation in the 10-week program.

Reduce travel and the costs of participation

Participation from home

Zoom appointments and groups removed travel and lodging demands.

Technology checks and real-time technical assistance supported virtual participation.

Costs and time

The program and all materials were provided at no cost.

Modest compensation recognized time spent on assessments and interviews.

Onboarding also explored whether financial assistance referrals were needed.

Include serious mental illness with support

Serious mental illness was not itself an exclusion.

Individual assessment	Understanding of study procedures, capability for consent, and ability to participate safely in the group were the key criteria.
Psychiatric medication stability	When psychiatric medication was used, eligibility included no initiation or dose changes during the eight weeks before entry.
Coordinated care	Communication with treating providers, with the participant's permission.

Williamson et al., 2026; NCT06191939;

Virtual access still leaves work to do

Language access	MSC-LC has been piloted in English; broader language accessibility remains a priority.
Digital resources	Provide direct support for internet and needed equipment.
Privacy and place	Address needs for private space and explore partnerships with local community resources.

Many people are willing to participate in clinical trials, but willingness alone does not ensure access

Promoting equity requires addressing barriers in people's daily lives, how care teams offer trials, and how institutions design and support participation.

Race and ethnicity
Consistent offers, language access, cultural humility, and community influence

Rural residence
Build local capacity and make remote delivery usable

Socioeconomic disadvantage
Fund support and reduce financial demands

Mental health conditions
Trial-specific eligibility and coordinate support for participation

Oyer et al., 2022; Guerra et al., 2023; Irwin et al., 2019

References

Abe (2020)
J Soc Work Educ, 56, 696–707.
Agaronnik et al. (2025)
Disabil Health J, 18, 101824.
Alsan et al. (2025)
J Health Econ, 100, 102968.
Barrett et al. (2023)
JCO Oncol Pract, 19, e570–e580.
Castro & Williamson (in preparation)
Unpublished manuscript.
Chen et al. (2025)
JAMA Netw Open, 8, e2515205.
Ezeoke et al. (2023)
The Oncologist, 28, 131–138.
Guerra et al. (2023)
JCO Oncol Pract, 19, e581–e588.
Hoadley et al. (2024)
JMIR Cancer, 10, e56048.
Irwin et al. (2019)
J Clin Oncol, 37, 1524–1528.
Irwin et al. (2019)
The Oncologist, 24, 901–910.
Kaljee et al. (2025)
JNCI Cancer Spectr, 9, pkae119.
Lui et al. (2026)
Support Care Cancer, 34, 733.
Nipp et al. (2016)
The Oncologist, 21, 467–474.
Niranjan et al. (2020)
Cancer, 126, 1958–1968.
Oyer et al. (2022)
J Clin Oncol, 40, 2163–2171.
Price et al. (2025)
Health Equity, 9, 53–59.
Reese & Williamson (2025)
JAMA Netw Open, 8, e2526612.
Riggan et al. (2023)
Cancer Med, 12, 8767–8776.
Sandoval et al. (2023)
J Cancer Educ, 38, 1271–1276.
Tervalon & Murray-García (1998)
J Health Care Poor Underserved, 9, 117–125.
Unger et al. (2016)
JAMA Oncol, 2, 137–139.
Unger et al. (2019)
J Natl Cancer Inst, 111, 245–255.
Unger et al. (2021)
J Natl Cancer Inst, 113, 244–257.
Unger et al. (2025)
CA Cancer J Clin, 75, 341–361.
Williamson et al. (2025)
Transl Behav Med, 15, ibae074.
Williamson et al. (2026)
Pilot Feasibility Stud, 12, 57.

MSC-LC trial registration: ClinicalTrials.gov — NCT06191939

Thank you!