Challenges and opportunities for studying teachable moments across the cancer continuum

Supported by Cancer Research UK Meeting Award
Sam Smith (University of Leeds)
   – State of science and research agenda

Claire Stevens (University College London)
   – Cancer screening as a teachable moment in ELSA

Rebecca Beeken (University College London)
   – Acceptability of teachable moment interventions

Linda Bauld (University of Stirling)
   - Behaviour change, cancer prevention and funding

Jamie Ostroff (Memorial Sloan Kettering Cancer Center)
   - Discussant of findings and future directions
Teachable moments: The state of science and research agenda

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Introduction

- Lifestyle linked with cancer incidence (including recurrence)
- ‘Cues to action’ are important for health behaviour change
- Cancer-related events (screening, Dx) could act as a cue?

This talk will provide:
- A critical overview of the TM concept
- Illustrative case studies of key research
- Suggestions for further research
"When the body is ripe, and society requires, and the self is ready to achieve a certain task, the teachable moment has come" (Havinghurst, 1953)
Teachable moments - definitions

- Intuitive concept, used widely with little consistency

- McBride et al., 2003 – spontaneous:
  ‘Naturally occurring life transitions or health events thought to motivate individuals to spontaneously adopt risk-reducing health behaviors’

- Rabin 2009 – prompted:
  ‘A window of time following an event in which a patient is more amenable to lifestyle change’
The who, what, where and how of teachable moments

- **Who** is susceptible to experiencing a teachable moment?

- **What** are the strategies that can be used within a teachable moment?

- **When** and **where** are the most suitable occasions for delivering a teachable moment intervention?

- **How** can a teachable moment be delivered?
Who is susceptible to experiencing a teachable moment?

- Spontaneous changes are rare, but not unknown
- Change could be positive or negative (‘health certificate’)
- Identifying who the individuals are that change could:
  - Guide development of intervention strategies
  - Improve timing of communication / discussion around lifestyle
Who – McBride tripartite model

Event

Perceived risk
Affective reactions
Self-concept

Teachable moment

Behaviour change

McBride et al., 2003 Health Educ Res
Who is susceptible to experiencing a teachable moment?

- Evidence for all parts of model and behaviour

- Few studies directly testing model
  - ‘Buy in’ to teachable moments intervention\(^1\)
  - Relatives of lung cancer patient and smoking cessation\(^2\)

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2. McBride et al., 2015 Psycho-Oncol
What are the strategies that can be used within a teachable moment?

- Bespoke interventions for teachable moments?

- The term ‘teachable’ implies we are to ‘teach’ them

- However, awareness of lifestyle → outcomes is poor
  - 13% general population linked alcohol with cancer\(^1\)
  - Red / processed meat (37%), fruit / veg (27\%)\(^2\)

- Awareness raising a good first step, but not sufficient?

2. ABACUS study (unpublished)
What – effecting strategies

- BeWel trial
  - 329 overweight / obese adults with screen-detected polyp
  - 3 face-to-face visits with counsellor plus monthly calls
    - Social Cognitive Theory: Goal setting, self monitoring, feedback
  - 2.7kg mean difference weight loss
  - 36% vs. 12% clinically meaningful (5%) weight loss

- Project Prevent
  - 1247 patients with screen-detected polyps
  - Telephone plus tailored materials
  - Sig reduction in risk factors (red meat, fruit / veg, alcohol, smoking)

- Could these strategies be delivered anywhere & any time?
When and where should teachable moments be delivered?

- **Cancer screening**¹
  - Attendees may be open to learning about cancer risk
  - Repeat screening - multiple opportunities for initiation & maintenance
  - Suitable infrastructure for large, cost-effective implementation
  - Little evidence for spontaneous change

- **Cancer survivorship**²
  - Multiple effective interventions (small, ‘soft’ outcomes, poor designs)
  - Psychological & supportive care needs fluctuate – when to intervene?
  - Clinicians concerned about raising issue
  - Patient preferences vary, but tripartite model (identity) suggests after?

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¹ Anderson et al., 2013 Cancer Pre. Res
² Denmark-Wahnefried et al., 2015 CA: Cancer Jnl Clin
When and where should teachable moments be delivered?

- Genetics and family history clinics
  - Example of women at high risk of breast cancer
  - Can alter identity (living in a space between wellness and ill health)
  - Heightens perceived risk
  - Often highly anxious and seeking prevention advice
  - Low interest in chemoprevention
  - Little evidence for spontaneous change, but some interventions

1. Maas et al., 2016 JAMA Oncology
2. Smith et al., 2016 Ann Oncol
How can teachable moment interventions be delivered?

- Delivery:
  - Health professionals (trustworthy)
  - Existing programmes (infrastructure)
  - Volunteers (cheaper, but less effective?)

- Intensity:
  - Some brief interventions in routine settings effective
  - Most effective TM interventions are complex interventions

- Modality:
  - Potential for non-face-to-face interventions in survivorship
  - Harnessing new technology (apps, social media, SMS) could enhance reach

1. Goode et al., 2015 J. Cancer Surviv
Recommendations for future research

- Studies testing all model components
- Experimental data
- Prospective data (Claire Stevens, Talk 2)
- Acceptability (Rebecca Beeken, Talk 3)
- Comparing different timings and moments
Conclusion

- Intuitive concept, with hidden complexity

- Identifying the who, what, when, where and how of teachable moments can optimise (existing) interventions

- Care should be taken around the term ‘teachable moment’
  - Competing definitions
  - Patients / public find it problematic
  - Intuitive concept – inhibits academic and scientific thought
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2016 12th Annual Scientific Meeting
Complex interventions in a complex world: applications of Behavioural Medicine

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Using prospective cohort data to investigate if colorectal cancer screening is a teachable moment for behaviour change:

Findings from the English Longitudinal Study of Ageing

Claire Stevens, Samuel G. Smith, Charlotte Vrinten, Jo Waller, Rebecca J. Beeken
Cancer screening as a teachable moment

- Limited evidence to suggest that cancer screening prompts spontaneous behavior change (e.g. van der Aalst et al., 2010)

- Some warnings that cancer screening may cause a ‘Health Certificate Effect’

Editorial

Screening could seriously damage your health

*BMJ* 1997;314:314. doi: http://dx.doi.org/10.1136/bmj.314.7080.533 (Published 22 February 1997)

Cite this as: *BMJ* 1997;314:533

Decisions to screen must take account of the social and psychological costs

Sarah Stewart-Brown, Director*, Andrew Farmer, Research associate*
Cancer screening in England

- Cervical screening: 25-64
- Breast screening: 50-70 (47-73)
- Bowel scope screening: 55
- Faecal occult blood testing: 60-74

- Men and women are exposed to cancer screening in different ways and at different ages.
- Importance of first screening (cardiovascular screening, Bretteville-Jensen et al., 2014).
To determine whether FOBt prompts spontaneous behavior change for smoking, alcohol consumption, F&V consumption and PA amongst first time screening participants
English Longitudinal Study of Aging (ELSA)

- A biennial prospective population based survey
- Data collection began in 2002/03, wave 7 data has recently been made available
- Studies the… ‘health, social, wellbeing and economic circumstances of the English population aged 50 and older.’
- Allows for cross-sectional and longitudinal analyses
Cancer screening

• Items assessing participation in cancer screening were added in Wave 5

  Have you ever completed the NHS bowel cancer screening test using the home test kit? (CAPI)

Health behaviours

• Smoking

  Do you smoke cigarettes at all nowadays? (CAPI)

• Alcohol consumption

  During the last seven days how many glasses of wine / beer (etc.) / measures of spirits did you have? (Self complete)

• Fruit and vegetable (F&V) consumption (Wave 5 onwards)

  How many portions of fruit / veg do you eat on a typical day? (Self complete)

• Vigorous physical activity (VPA)

  Do you take part in sports or activities that are vigorous...
  More than once a week / once a week / one to three times a month / hardly ever or never (CAPI)
• Men aged 57-59 at baseline **AND** 60-61 at follow-up (n=774), without a diagnosis of cancer at baseline or follow-up

<table>
<thead>
<tr>
<th>Group</th>
<th>Baseline</th>
<th>Follow-up</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Wave 4</td>
<td>Wave 5</td>
</tr>
<tr>
<td>2</td>
<td>Wave 5</td>
<td>Wave 6</td>
</tr>
<tr>
<td>3</td>
<td>Wave 6</td>
<td>Wave 7</td>
</tr>
</tbody>
</table>
FOBt participation 63%

White 95%

Educated to degree level or above 31%

When in work – managerial or professional occupation 47%

Baseline retirement 12%, follow-up retirement 24%

Participants who took part in FOBt were more likely to be retired at follow-up. No other demographic differences.
Generalised estimating equations

1. Effects of group - differences between groups (attenders, non-attenders) for health behaviours (smoking, alcohol, physical activity, fruit and veg).

2. Effects of time – changes in behaviours over time

3. Interaction of group x time

All analyses were adjusted for ethnicity, occupation, education, limiting long-standing illness, retirement status and group.
RESULTS - SMOKING

Proportion of smokers over time, by screening participation (n=730)

- FOBt participants less likely to smoke
- Smoking decreased over time
- No interaction between FOBt participation and time
Proportion of people meeting guidelines for alcohol consumption over time, by screening participation (n=708)

- No relationship between FOBt participation and alcohol consumption
- Alcohol consumption decreased over time
- No interaction between FOBt participation and time
RESULTS – FRUIT AND VEGETABLE CONSUMPTION

Proportion of people meeting guidelines for F&V consumption over time, by screening participation (n=511)

- FOBt participants more likely to meet F&V guidelines
- No effect of time on F&V consumption
- No interaction between FOBt participation and time
Results – Vigorous Physical Activity

Proportion of people reporting VPA once or more per week over time, by screening participation (n=774)

- No relationship between FOBt and VPA
- No effect of time on VPA
- Significant Interaction between FOBt participation and time

P<0.015
STRENGTHS & LIMITATIONS

Strengths

- Novel approach
- Novel sample

Limitations

- Not possible to assess short term changes in health behaviour
- Picture may be different for other screening programmes, including bowel scope screening
- Self-report data
- Proportion of participants attending FOBt
- Representativeness of the sample
CONCLUSIONS

• It is encouraging that participation in FOBt does not appear to cause negative behaviour change

• Overall there is limited evidence for longstanding spontaneous improvement in multiple health behaviours following FOBt participation

• However, this research provides tentative support for FOBt as a teachable moment for vigorous physical activity

• Opportunity for conversations about behaviour change and interventions within this context

Future research

• Other large scale longitudinal studies

• Other screening programmes
Thank you for listening!
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ACCEPTABILITY OF DELIVERING LIFESTYLE INTERVENTIONS IN TEACHABLE MOMENTS AT CANCER SCREENING

Rebecca J. Beeken, PhD

Health Behaviour Research Centre
Department of Epidemiology & Public Health
University College London

Claire Stevens, Sam Smith, Charlotte Vrinten,
Jo Waller & Rebecca J Beeken
Background

• Limited evidence for spontaneous behaviour change at screening

• ‘A window of time following an event in which a patient is more amenable to lifestyle change’ (Rabin, 2009)

• How willing are patients to receive lifestyle advice within these moments?
• Interested volunteers = 55% of the screening participants targeted (range 51–63%)

• Interest in diet & exercise advice at breast screening = 86%, with the majority (91%) stating it would have no effect on willingness to attend (Fisher et al, 2007)
Aim

To explore how willing people are to receive lifestyle advice at cancer screening

– In what circumstances?
– When?
– Who?
– What type?
Methods

- Third wave of the Attitudes, Behaviour And Cancer UK Survey (ABACUS)
  - Cross-sectional
  - Population representative sample of people living in England (18-70 years old)
  - Identified and recruited by market research company ‘TNS’ using a field-based computer assisted interview as part of omnibus survey
## Methods

Total sample: 2048

<table>
<thead>
<tr>
<th>Cervical</th>
<th>Breast</th>
<th>Bowel</th>
</tr>
</thead>
<tbody>
<tr>
<td>920 women (18-64)</td>
<td>420 women (47–70)</td>
<td>308 men &amp; women (45-54)</td>
</tr>
</tbody>
</table>
Methods

• Screening/TM items
  • E.g. ‘Would you be willing to receive advice about making healthy lifestyle changes (for example, diet or physical activity) as part of the cervical/breast/bowel screening programme?’

• Health behaviours
  • Alcohol consumption
  • Physical activity
  • Fruit & veg intake
  • Smoking status
  • Height and weight

• Other variables
  • Cancer risk factor awareness
  • Self-reported health
  • Comparative cancer risk
1. Are intenders willing to receive lifestyle advice at screening?
2. Would non-intenders be more willing to attend?
3. Will intenders be put off attending?

- Cervical (n=796):
  - More willing to attend: 30%
  - Less willing to attend: 5%
  - Would not affect willingness to attend: 65%

- Breast (n=321):
  - More willing to attend: 35%
  - Less willing to attend: 7%
  - Would not affect willingness to attend: 58%

- Bowel (n=241):
  - More willing to attend: 20%
  - Less willing to attend: 10%
  - Would not affect willingness to attend: 70%
4. Willing to receive advice if further investigations are needed?
5. When should information be given?

- **At the same time as the screening appointment**
- **With screening results**
- **2-4 weeks after attending**
- **> 1 month after attending**

### Cervical (n= 628)
- At the same time as the screening appointment: 70%
- With screening results: 20%
- 2-4 weeks after attending: 10%
- > 1 month after attending: 0%

### Breast (n=274)
- At the same time as the screening appointment: 72%
- With screening results: 24%
- 2-4 weeks after attending: 4%
- > 1 month after attending: 0%

### Bowel (n=194)
- At the same time as the screening appointment: 71%
- With screening results: 28%
- 2-4 weeks after attending: 1%
- > 1 month after attending: 0%
6. What predicts willingness to receive information at screening?

• Cervical
  – Non-white (OR: 2.25, 95%CI: 1.15-4.38)
  – Qualifications below degree (OR: 0.57, 95%CI: 0.36-0.91)
  – Cancer risk factor awareness (OR: 1.08, 95%CI: 1.01-1.16)

• Breast
  – No significant predictors

• Bowel
  – Female (OR: 2.36, 95%CI: 1.13-4.96)
  – Cancer risk factor awareness (OR: 1.28, 95%CI: 1.11-1.48)
7. What type of information do willing intenders want?

- Diet (n=1372)
- Weight (n=1372)
- Physical activity (n=1366)
- Smoking (n=1361)
- Alcohol (n=1361)
8. What predicts willingness to receive different types of information at screening?

• Dietary advice
  – Non-white (OR: 1.97, 95%CI: 1.27-3.05)
  – Recognises red meat as risk factor (OR: 1.33, 95%CI: 1.32-1.77)

• Weight
  – Non-white (OR: 1.73, 95%CI: 1.14-2.62)
  – Future attender (OR: 1.47, 95%CI: 1.02-2.14)
  – Overweight (OR: 2.00, 95%CI: 1.53-2.63)
8. What predicts willingness to receive different types of information at screening?

- Physical activity
  - Non-white (OR: 2.20, 95%CI: 1.44-3.35)
  - Social grade C1 (OR: 1.45, 95%CI: 1.01-2.07)
  - Recognises risk factor (OR: 1.34, 95%CI: 1.04-1.73)
8. What predicts willingness to receive different types of information at screening?

**Smoking**
- Non-white (OR: 2.15, 95%CI: 1.33-3.48)
- Social grade C2 (OR: 1.87, 95%CI: 1.01-3.44)
- Social grade DE (OR: 2.37, 95%CI: 1.30-4.30)
- Current smoker (OR: 12.37, 95%CI: 8.48-18.05)

**Alcohol**
- Age (OR: 0.98, 95%CI: 0.97-0.99)
- Meets guidelines (OR: 0.40, 95%CI: 0.28-0.58)
- Recognises risk factor (OR: 1.69, 95%CI: 1.31-2.18)
Conclusions

• The provision of lifestyle advice at cancer screening is likely to be acceptable to the majority of attendees.

• Most would like this advice at their screening appointment, and regardless of screening outcome.

• Potentially promising for delivering information to ‘hard to reach’ groups.

• Increasing awareness of risk factors and own behaviours may be useful targets for increasing acceptability (but not perceived risk?)

Limitations

• Hypothetical scenario
• No comparator
• Self-reported health behaviours
Future Research

- How do we manage potential negative effects?
- Feasibility of providing information at screening
- Uptake of advice offered in ‘real-life’ screening settings (and subsequent behaviour change)
- Other moments along the cancer continuum?
  - Cancer diagnosis
  - Family member’s diagnosis
  - Genetic testing
Thank you for listening

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<table>
<thead>
<tr>
<th>Proportion of people recognising cancer risk factors (CAM)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit and vegetable consumption (n=1425)</td>
<td>29</td>
</tr>
<tr>
<td>Red meat (n=1428)</td>
<td>39</td>
</tr>
<tr>
<td>BMI (n=1428)</td>
<td>60</td>
</tr>
<tr>
<td>Physical activity (n=1430)</td>
<td>34</td>
</tr>
<tr>
<td>Smoking (n=1431)</td>
<td>85</td>
</tr>
<tr>
<td>Alcohol consumption (n=1431)</td>
<td>41</td>
</tr>
</tbody>
</table>
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Teachable moments, cancer prevention & funding opportunities

Linda Bauld, University of Stirling & Cancer Research UK
Outline

• Cancer prevention
• Key risk factors: smoking, alcohol, overweight & obesity
• Opportunities for funding and collaboration
We need to prevent more cancers 40% are linked to preventable risk factors.
Cancer Prevention Ambitions

1. Create a “tobacco free” UK by 2035 (less than 5% prevalence)
2. Stall and see a decline in the proportion of adults who are overweight and obese and see a significant decline in the proportion of children who are overweight and obese
3. Reduce overall consumption of alcohol with an emphasis on hazardous and harmful drinking
4. Stall or reduce the incidence of melanoma, through limiting harmful UV radiation exposure
Smoking and Cancer

• Tobacco use is the leading preventable cause of cancer, accounting for 64,500 cases in the UK each year
• Smoking cessation is relevant for primary and secondary prevention
• Preventing smoking uptake is also important in reducing tobacco-related cancers in the future
Alcohol and Cancer

- Alcohol is responsible for around 12,800 cancers in the UK every year.
- A large proportion of head and neck cancers are caused by alcohol – e.g. 30% of UK mouth cancers.
- But because the underlying risk is higher, alcohol is responsible for more cases of breast and bowel cancer – a combined total of around 8,000 cases a year.
Mechanisms

ONE WAY ALCOHOL CAUSES CANCER

ETHANOL (ALCOHOL)

ADH is an enzyme that converts ethanol into acetaldehyde

IF A SMALL AMOUNT OF ALCOHOL IS DRUNK...
The body can process it, so that it passes through without doing much damage

ALDH is an enzyme that converts acetaldehyde into acetate

People with mistakes in the genetic code of ALDH can’t break acetaldehyde down – they are more prone to certain cancers. Mistakes in ALDH are common among Asian populations

ACETALDEHYDE can cause:
- Mistakes in DNA
- Chromosome rearrangements
- DNA to bind and form clumps

ACETATE Energy that the body can use
Newer evidence on additional links


Estimate of RR of prostate cancer mortality for low volume consumers (up to 24g or 3 units of alcohol per day):
1. Pooled estimate for all 27 studies: **RR=1.08**, 1.04-1.11, p<0.0001
2. Estimate for 6 studies free of former and occasional drinker bias: **RR=1.23**, 1.05-1.45, p=0.014

*More studies are needed which are free of abstainer biases to better quantify alcohol’s contribution to cancer.*
Obesity and Cancer

- Overweight and obesity is responsible for around 18,100 cancers in the UK every year.
- If current trends continue, it will lead to a further 670,000 cancer cases over the next 20 years.
- Overweight and obesity is linked to some of the most common types of cancer like breast and bowel cancer—and some of the hardest to treat like pancreatic and oesophageal cancer.
How Could Obesity Lead to Cancer?

1. OESTROGEN
   After the menopause, oestrogen made by fat cells can make cells multiply faster in the breasts and womb, increasing the risk of cancer.

2. INSULIN AND GROWTH FACTORS
   Excess fat can cause levels of insulin and other growth factors to rise, which can also tell cells to divide more rapidly.

3. INFLAMMATION
   Cells in fat called macrophages release chemicals called cytokines, encouraging cells to divide (including cancer cells).

There are other theories too, but these are the main ideas being studied. More research is needed to understand this in more detail.
Raising awareness

- CRUK is working to raise awareness of the links between alcohol and cancer.
- As in other countries, current knowledge levels are low, compared to the understanding of the links between tobacco use and cancer.

CANCER AWARENESS

Only around 1 in 10 people linked cancer as a potential health condition resulting from drinking too much alcohol.*

*When asked “Which, if any, health conditions do you think can result from drinking too much alcohol?”

We must invest more in national health campaigns so that more people are aware of the long term risks of drinking.
Awareness of cancer types & alcohol

% who correctly thought drinking alcohol increased the risk of the following cancers:
- Mouth & Throat: 48%
- Breast: 18%
- Liver: 80%
- Bowel: 39%

Number of cancer cases caused by alcohol in the UK each year:
- Mouth & Throat: 2,100
- Breast: 3,200
- Liver: 400
- Bowel: 4,800

Let's beat cancer sooner. cruk.org
Obesity Awareness

PUBLIC AWARENESS OF THE INCREASED CANCER RISK CAUSED BY BEING OVERWEIGHT/OBESE

Around 3 in 4 people did not think cancer could result from being overweight or obese.*

OVERWEIGHT/OBESE AND CANCER RISK AWARENESS IN DIFFERENT SOCIAL GRADES

People from lower social grades are less aware of the link between cancer and bodyweight than those in higher social grades.*

AWARENESS OF FOUR CANCER TYPES LINKED TO OVERWEIGHT AND OBESITY

% who correctly thought being overweight or obese increased the risk of the following cancers

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Percentage</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>31%</td>
<td>4,300</td>
</tr>
<tr>
<td>Kidney</td>
<td>44%</td>
<td>2,400</td>
</tr>
<tr>
<td>Bowel</td>
<td>60%</td>
<td>5,400</td>
</tr>
<tr>
<td>Womb</td>
<td>22%</td>
<td>2,900</td>
</tr>
</tbody>
</table>

Number of cases caused by being overweight or obese in the UK each year
OB_S__Y
causes cancer

Guess what is the biggest preventable cause of cancer after smoking.
EVEN SMALL REDUCTIONS IN OBESITY COULD PREVENT CANCER AND SAVE MONEY

Reducing being overweight and obese by 1% every year could...

- AVOID 64,200 CASES OF CANCER OVER THE NEXT 20 YEARS
- SAVE £40M IN THE ANNUAL COST OF NHS CANCER CARE
- AVOID 7,300 CASES OF CANCER ANNUALLY FROM 2035
Collaborate with us on Cancer Prevention

- **National Leadership**
  - Cancer Prevention Champion & Advisory Board

- **Innovation**
  - “Sandpit Workshops” Grants up to £20,000

- **Action**
  - Policy Research Centre for Cancer Prevention

- **Sustainability**
  - Cancer Prevention Fellowships
Sandpit workshops

- Four workshops held so far and a fifth on physical activity planned for July 2017
- Brings together researchers and practitioners from a wide range of disciplines
- Development of proposals and pitching for up to £20,000 ‘seed’ funding
- Support to develop future larger proposals from promising projects

Example: What Works in ‘Park Run’ – expanding a citizen-led physical activity approach
Conversation Time: Exploring predictors of receptiveness to a discussion about physical activity and cancer prevention

- PI: Rebecca Beeken, UCL

Co-investigators
- Katherine Bradbury (University of Southampton)
- Mangesh Thorat (QMUL)
- Daniel Powell (University of Aberdeen)
- Meghana Kamble (UEA)
- Grace Okoli (KCL)
Conversation Time

Aim: To explore the feasibility of identifying potential predictors of receptiveness to a conversation about physical activity and colorectal cancer prevention, using ecological momentary assessments

Potential impact:
• A logic model to help healthcare professionals make decisions about who to engage in such conversations
• Potential targets for interventions seeking to improve receptiveness
Joint Sandpit with NCI

- We are also now planning a joint UK/USA workshop with the National Cancer Institute
- To be held in Washington, DC April 24th-26th 2017
- We’ll be issuing a call for applications from UK researchers and others soon
- Please contact Abby.Woodfin@cancer.org.uk for more information
Other funding opportunities

• CRUK’s Population Research Committee offers larger grants for programmes and projects on cancer prevention, cancer epidemiology and early diagnosis

• CRUK’s Early Diagnosis Advisory Committee (EDAG) and Tobacco Advisory Group (TAG) offer funding for more applied research

• Contact Rebecca.Wise@cancer.org.uk for more information
Thank you

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