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Submission to the House Committee on Education and Employment
Inquiry into mental health and workforce participation

May 2011

Our Credo

We believe our first responsibility is to the doctors, nurses and patients,
to mothers and fathers and all others who use our products and services.
In meeting their needs everything we do must be of high quality.
We must constantly strive to reduce our costs
in order to maintain reasonable prices.
Customers' orders must be serviced promptly and accurately.
Our suppliers and distributors must have an opportunity
to make a fair profit.

We are responsible to our employees,
the men and women who work with us throughout the world.
Everyone must be considered as an individual.
We must respect their dignity and recognize their merit.
They must have a sense of security in their jobs.
Compensation must be fair and adequate,
and working conditions clean, orderly and safe.
We must be mindful of ways to help our employees fulfill
their family responsibilities.
Employees must feel free to make suggestions and complaints.
There must be equal opportunity for employment, development
and advancement for those qualified.
We must provide competent management,
and their actions must be just and ethical.

We are responsible to the communities in which we live and work
and to the world community as well.
We must be good citizens – support good works and charities
and bear our fair share of taxes.
We must encourage civic improvements and better health and education.
We must maintain in good order
the property we are privileged to use,
protecting the environment and natural resources.

Our final responsibility is to our stockholders.
Business must make a sound profit.
We must experiment with new ideas.
Research must be carried on, innovative programs developed
and mistakes paid for.
New equipment must be purchased, new facilities provided
and new products launched.
Reserves must be created to provide for adverse times.
When we operate according to these principles,
the stockholders should realize a fair return.

Table of Contents

OUR CREDO 2

1. SUBMISSION INFORMATION 4

2. ABOUT JANSSEN 5

3. HELPING AUSTRALIANS WITH PERSISTENT MENTAL ILLNESS 6

4. EXECUTIVE SUMMARY 7

5. PREVALENCE OF SCHIZOPHRENIA 8

6. RECOVERY AND RETURNING TO WORK IN SCHIZOPHRENIA 9

- TREATMENT HELPS INDIVIDUALS RETURN TO WORK AND EDUCATION 9
- THE HUMAN AND ECONOMIC COST OF RELAPSE 10
- RELAPSE IN SCHIZOPHRENIA - A BARRIER TO WORKFORCE PARTICIPATION 10
- PRODUCTIVITY LOSS DUE TO RELAPSE RELATED SUICIDE 11
- PRODUCTIVITY LOSS DUE TO CRIMINALITY 12

7. THE POTENTIAL FOR LONG-ACTING THERAPIES TO REDUCE RELAPSE 13

6. CONCLUSION 14

7. REFERENCES 15

1. Submission Information

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Declaration of Interest:

Janssen is engaged in business located in Australia and is the sponsor of a number of medicines listed on the Pharmaceutical Benefits Schedule, including biological medicines.

2. About Janssen

"Caring for the world, one person at a time"

With more than 50 years experience in the research and development of medicines for mental health, Janssen is focussed on bringing hope and health to Australians living with persistent mental illness and their families.

Janssen is a leading research-based pharmaceutical company with a distinguished heritage in mental health. We are committed to improving the standard of care for those affected by persistent mental illness and neurological disorders, including schizophrenia, bipolar disorder, Alzheimer's disease and Attention Deficit Hyperactivity Disorder (ADHD).

Janssen also provides prescription medicines for a range of other conditions including neurology, women's health, haematology, gastroenterology, and pain management. Four Janssen medicines are included in the World Health Organisation's Essential Drug list.

The research conducted by Janssen has resulted in a number of critical medicines being developed and made available to the Australian public.

3. Helping Australians with Persistent Mental Illness

We are responsible to the communities in which we live and work
and to the world community as well.
We must be good citizens – support good works and charities
and bear our fair share of taxes.
We must encourage civic improvements and better health and education.
Our Credo

As reflected in our Credo, we believe we have a responsibility not only to our customers, but also to the communities in which we live. This means ensuring that we do all we can to enable Australians living with persistent mental illness to live healthy and productive lives; including accessing education, training and employment opportunities.

Janssen is a world leader in the research and development of medicines in mental health, with a focus on schizophrenia. Since the 1950s, Janssen has invested in developing long-acting antipsychotic treatments that encourage adherence, reduce relapse and help people live productive lives in the community.

People living with schizophrenia need access to a combination of clinical care, including medication, psychological therapy and social support in order to achieve the best outcomes. At Janssen, we consider it our responsibility to look beyond the provision of medication and support projects that support Australians living with mental ill health and their loved ones.

Primarily, we do this by supporting educational and social inclusion projects lead by mental health consumer groups. We are proud to support organisations such as the Mental Health Council of Australia, SANE Australia and the Mental Illness Fellowship of Australia because they provide vital support and make a real difference in people's lives.

Nonetheless, it is well documented that antipsychotic medication is the cornerstone of the management of schizophrenia (Psychotropic Therapuetic Guidelines 2008). In order to continue to develop new and innovative products, companies such as Janssen seek strong, clear and effective regulatory and reimbursement systems.

We therefore welcome this opportunity to contribute to this inquiry into mental health and workforce participation. In this submission, we discuss schizophrenia and antipsychotic medications that are designed to encourage adherence, reduce relapse and help consumers live productive lives. We also comment on how recent changes in the reimbursement environment jeopardise the future development of such treatments.

4. Executive Summary

This submission focuses on persistent mental illness, specifically schizophrenia, and selected ways to address barriers and enhance access to and participation in education, training and employment.

Specifically, we consider how relapse in schizophrenia affects an individual's ability to return to work and/or education, and the resultant broader economic costs of relapse. We suggest Australians living with persistent mental illness, such as schizophrenia, must have access to new and innovative medicines that encourage adherence and reduce the rate of relapse, in order to address barriers and enhance access to education, training and employment.

People living with severe mental illness can and do make good recoveries. However, it is widely accepted that consumers need access to a combination of psychological therapy, social support and clinical care, including medication, in order to achieve the best outcomes. Janssen is extremely concerned with Cabinet's recent decision to defer the PBS listing of a critical new medicine, Invega Sustenna® (paliperidone palmitate) which is proven to reduce relapse and help people live more productive lives.

Janssen recently commissioned a report by Deloitte Access Economics regarding the cost of relapse in schizophrenia. This submission utilises this report and is designed to better inform the members of the committee of the cost of relapse and how the prevention of relapse is a crucial element in helping Australians with persistent mental ill health return to work and education.

5. Prevalence of Schizophrenia

A Deloitte Access Economics report commissioned by Janssen in 2011 estimates there were 98,437 Australians living with schizophrenia in 2010, comprising 54,843 males and 43,594 females.

Schizophrenia is a serious, persistent mental illness that affects an individual's thought processes and emotional responsiveness and robs people of their productive lives. Over 40% of schizophrenia individuals attempt suicide, 70% do not work and almost all experience social isolation (Access Economics 2002).

A person with schizophrenia has an average lifetime that is 9-12 years shorter than the general population. This is due to a number of factors including, preventable behavioural risk factors, an increased prevalence of untreated co-morbidities and suicide (Deloitte Access Economics 2011).

A disproportionate number of people living with schizophrenia commit suicide. Saha et al (2007) found that people with schizophrenia were 13 times more likely commit suicide, while Auquier et al (2006) and Pompili et al (2007) identified estimates of around 10 and eight times respectively.

These troubling statistics demonstrate that schizophrenia comes with high costs, both human and economic. Janssen therefore welcomes this Inquiry and encourages the Committee to explore every opportunity to help consumers return to work and education.

6. Recovery and Returning to Work in Schizophrenia

Treatment helps individuals return to work and education

To return to work and education, Australians living with schizophrenia need access to a combination of psychological therapy, social support and clinical care, including medication.

To address barriers and enhance access to education and training it is fundamental that the Federal Government invest in strong clinical and community support programs. This must include building a strong and effective reimbursement system to ensure consumer access to new and innovative antipsychotic medicines that encourage adherence and reduce the rate of relapse.

Adherence to antipsychotic therapy is perhaps the biggest challenge in the treatment of schizophrenia with non-adherence being the largest single cause of relapse (Psychotropic Therapeutic Guidelines, 2008). Janssen is therefore extremely concerned with Cabinet's recent decision to defer the PBS listing of a critical new medicine, Invega Sustenna® (paliperidone palmitate) which is proven to reduce relapse and help people live more productive lives.

Nonetheless, Janssen understands medication is only part of the solution. We believe consumers need access to a range of treatments in order to recover and return to work and education. In our experience, these include:

- Services provided by non-profit mental health consumer organisations, such as consumer and carer education, programs to help individuals return to work and education, advocacy and so on;
- Residential care that provides a temporary home for people experiencing acute mental ill health where they can rehabilitate and learn skills necessary for living in the community;
- Community mental health care providing a range of support services, such as: case management; multidisciplinary care; accommodation and community support; community access services; respite services; and employment support services.
- Supported Accommodation Assistance Program (SAAP), which assists those homeless or at risk of being homeless with transitional supported accommodation and other support services;

The Human and Economic Cost of Relapse

Janssen believes relapse prevention is crucial in caring for people with persistent mental illness and in helping individuals recover and return to work and education.

Deloitte Access Economics defined relapse in schizophrenia as an admitted episode of hospital care that resulted in at least one overnight stay. This represents a significant worsening of symptoms, decrease in social function and change in the pattern of care. **The number of relapses in people living with schizophrenia in Australia was estimated to be 25,571 over a 12 month period in 2009-10** (Deloitte Access Economics 2011)**.**

As people living with schizophrenia who do not relapse use health care and other economic resources, the cost of a relapse was estimated by the additional resources used (or resources lost in terms of productivity) due to relapse. The total cost of relapse in people with schizophrenia was estimated to be $698.6 million over a 12 month period in 2009-10**. This includes $210 million in indirect costs such as lost productivity due to unemployment and premature mortality** (Deloitte Access Economics 2011)**.**

Relapse in schizophrenia - a barrier to workforce participation

Relapse in schizophrenia affects an individual's ability to maintain employment. In its report on the Cost of Relapse in Schizophrenia, Deloitte Access Economics highlights several studies demonstrating the productivity losses associated with relapse.

Drawing on studies such as Jablensky et all 1999, Marwaha and Johnson 2004, and Hong et al 2009; Deloittes Access Economics estimated the implied employment rate for people experiencing a relapse is 24.8%, in comparison to 31.3% among those who do not. Applying this to the estimated number of relapses in 2010 implies that 6,340 people who relapsed were working at the time. This is approximately 21.8% of the 29,125 employed people with schizophrenia.

Comparing the number of people with relapse employed with the number that would have employment in the absence of the relapse (31.3% or 8,001) there are 1,661 people unemployed at any one time as a due to a relapse. This equates to an average length of unemployment of approximately three months due to relapse (including time spent in hospital).

IMS Health (2006) suggested that the average weekly earnings of a person with schizophrenia are significantly less than the general population. Deloitte Access Economics estimated 6,340 people stopped employment due to a relapse in 2009-10. Throughout this period, there were approximately 1,661 people not employed at any one time due to relapse. Considering the average annual earnings of an individual living with schizophrenia is $14,778 (Deloitte Access Economics 2011), the value of lost productivity due to a relapse was estimated to be $24.5 million annually.

Productivity loss due to relapse related suicide

In addition to productivity loss associated with unemployment, there is also productivity foregone from premature mortality due to relapse. Tragically, Shrivastava (2010) found that **the rate of suicide was almost four times greater for those not adhering to medication compared to those who did**. It is therefore assumed that **the effect of non-adherence is indicative of the effect of a relapse** and **80% of suicides are therefore attributed to schizophrenia relapse.**

In 2009-10, there were an estimated 159 suicides by people with schizophrenia of which 127 were assumed attributable to schizophrenia relapse (Deloitte Access Economics 2011). Assuming the probability of employment for those who decide to take their own lives due to relapse is the same as that for all people living with schizophrenia, 24.8% (approximately 32 people) are expected to have been employed had they not died due to a relapse related suicide.

Deloitte Access Economics estimates the 'mortality burden' of suicides as the value of income that individuals would have earned up to retirement (age 65 years) had they not died. Considering the the average annual income in 2010 of a person with schizophrenia is $14,777, the total income lost due to relapse related suicide in Australia in 2009-10 is estimated to be $5.2 million.

Productivity loss due to criminality

People living with schizophrenia are not especially prone to violence — more typically they are withdrawn and prefer to be left alone. As with the community generally, the rate of violence is increased if there is substance abuse or a history of criminal violence (before onset of the disease).

However, there is an elevated risk of criminality. Fazel and Danesh (2002) estimated average psychosis prevalence rates in prisons for females and males were 3.7% and 4.0% respectively. This means the psychosis rates of persons in prison are 3-4 times the rate of the general population.

Risk of a criminal offence increases if a person is paranoid with psychotic symptoms and medication is discontinued. In a US study, Ascher-Svanum et al (2010) found **people who had relapsed in the previous six months were more than twice as likely to have been arrested than those who had not** (4.0% versus 9.7%).

7. The Potential for Long-Acting Therapies to Reduce Relapse

In many cases poor adherence with medication to treat schizophrenia is associated with a substantial increase in the risk of a relapse. Eighty percent of people are expected to experience a relapse if they have poor adherence (Psychotropic Therapeutic Guidelines 2008).

It is generally accepted that adherence for oral antipsychotics (both typical and atypical) is low. For example, Dolder et al (2001) found that adherence for oral atypical and typical antipsychotics were similarly poor at 12 months, with 54.9% and 50.1% respectively. At two years adherence may be as low as 25% (Chue 2010).

It is well documented that long-acting injectable antipsychotic medicines, such as Invega Sustenna, have the potential to reduce the rate of relapse and thereby help individuals live more productive lives. There are several reasons why long-acting injectable (LAI) antipsychotics promote adherence and help reduce relapse, including the fact that they are administered less frequently and non-adherence is easier to detect as the medication is administered by medical professionals.

In Australia, approximately 17% of people with schizophrenia are prescribed LAIs (Monshat et al 2010). Deloitte Access Economics estimated that if LAI antipsychotic utilisation was increased to 30% in Australia (as in the UK and US), there would be an additional 12,791 people prescribed a LAI. **Assuming all people switched were non-adherent to oral antipsychotics, the avoided cost of relapse through improved adherence to medication would be approximately $52.5 million per year** (Deloitte Access Economics 2011).

This figure not only represents the financial costs that could be avoided, but the potential increase in productivity should individuals be given an opportunity to stay well and avoid relapse through an increased use of long-acting therapy.

6. Conclusion

Relapse in schizophrenia is a significant barrier to participation in education, training and employment. Nevertheless, people living with schizophrenia can do and make good recoveries when they have access to a broad range of treatments, including psychological therapy, social support and clinical care, including medication.

We encourage the Government to continue to invest in vital programs implemented by mental health consumer organisations and to build stronger, more connected public mental health services.

However, we believe that in order to enhance access to and increase participation in education, training and employment, it is essential for Australians living with persistent mental illness to have access to medicines that encourage adherence and reduce the rate of relapse.

Janssen is extremely concerned with Cabinet's recent decision to defer the PBS listing of a critical new medicine, Invega Sustenna® (paliperidone palmitate) which is proven to reduce relapse and help people live more productive lives. We encourage the Government to review this decision in the interest of the thousands of Australians living with schizophrenia and their families.

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