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The Adjudication of Sexual Dysfunction Claims Consequential to an Entitled Psychiatric Condition

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Executive Summary

In 2018, Veterans Affairs Canada (VAC) changed its decision-making processes by streamlining erectile dysfunction claims that are related to a psychiatric condition. As part of our focus on possible barriers to equitable access to programs and services for women Veterans, the Office of the Veterans Ombud (OVO) investigated whether there is a sex-based bias in VAC decision-making processes for sexual dysfunctions related to psychiatric conditions.

Why this issue is important

Veterans may experience sexual dysfunction related to their service, specifically as a result of conditions like post-traumatic stress disorder (PTSD) and the medications that treat them. Sexual dysfunction can significantly affect mental health and quality of life for male and female Veterans.

What we found

OVO reviewed VAC processes for handling sexual dysfunction claims related to psychiatric conditions. Our review found systemic unfairness for female Veterans in certain decision-making processes. We also found serious limitations in the availability of accurate VAC client data. These limitations made it impossible for us to measure the impact of the systemic sex-based biases we uncovered. This report delivers five recommendations to address the issues we found.

Key findings and recommendations

- VAC streamlines applications for male Veterans with erectile dysfunction caused by medications to treat psychiatric conditions. Sexual dysfunction applications for female Veterans have no equivalent process. Yet, research shows that medications to treat psychiatric conditions like PTSD cause sexual dysfunction in both males and females.

Recommendation 1: *Eliminate the sex-based bias in the VAC adjudication of sexual dysfunction claims consequential to a psychiatric condition. One way would be to use the same approach to decision-making for both male and female claims.*

- The VAC medical questionnaire for sexual dysfunction makes it easier for male clients to be clearly diagnosed with a sexual dysfunction than for female clients. This questionnaire contains a checklist that includes male sexual dysfunctions, but there is no checklist of female sexual dysfunctions. This means establishing a diagnosis for female sexual dysfunction is less straightforward.

  Recommendation 2: *Update the PEN 68e Medical Questionnaire to equitably capture sexual dysfunctions affecting all clients.*

- The *Table of Disabilities* (TOD) contains impairment ratings used to standardize the assessment of common conditions and the corresponding compensation amounts. There are two impairment ratings for male sexual dysfunctions and only one for female sexual dysfunctions. This means the process for deciding benefits for female sexual dysfunctions must be done case-by-case, which may lead to inconsistent decisions and lengthier wait times.

  Recommendation 3: *Update the Table of Disabilities to include impairment ratings for all sexual dysfunctions listed in contemporary diagnostic manuals to standardize the adjudication process for all clients.*

- The process for adjudicating the symptom of decreased libido bracketed with a psychiatric condition is unclear. Female Veterans are more likely to experience desire and arousal disorders that VAC adjudicates as decreased libido;[1] however, this is not clearly defined in the *Entitlement Eligibility Guidelines* for psychiatric conditions. This may lead to unfair outcomes and longer wait times for female Veterans.

  Recommendation 4: *Provide clearer guidance for adjudicating female sexual dysfunction claims consequential to a psychiatric condition by defining decreased libido in the psychiatric Entitlement Eligibility Guidelines.*

- Our analysis was limited because VAC does not adequately collect data related to sexual dysfunction claims. This lack of data granularity makes it impossible not only for us to evaluate the impact of sex-based bias on the adjudication of sexual dysfunction claims, but also for VAC to adequately understand the nature of the sexual dysfunction claims submitted by all clients.

  Recommendation 5: *Refine the granularity of the data collection system in order to fully capture the nature of sexual dysfunction claims, including for decreased libido, in the diverse VAC client population.*

Summary

Overall, our recommendations are focused on the processes used by VAC to adjudicate claims for sexual dysfunctions related to psychiatric conditions. Amending those processes could assist decision-makers to ensure

[1] As of November 2021.

clients with sexual dysfunctions other than erectile dysfunction are not waiting longer or experiencing unfair outcomes. VAC has already begun to address some of the issues identified in this report. In January 2022, VAC released a new *Sexual Dysfunction Entitlement Eligibility Guideline* and is apparently planning to update the *Table of Disabilities* and the *PEN 68e Medical Questionnaire*.

INTRODUCTION

The OVO conducted this investigation to determine whether Veterans have equitable access to fair and timely decisions for sexual dysfunction disability benefits regardless of their sex.[2] As part of our work to identify barriers experienced by women Veterans, we were concerned by an internal VAC adjudication directive that streamlined the processing of claims for erectile dysfunction consequential to an entitled psychiatric condition (VAC, 2018).[3] No similar directive exists for other sexual dysfunction claims, including those made by female clients.

Our investigation uncovered sex-based biases in the instruments and processes VAC uses to adjudicate sexual dysfunction claims consequential to entitled psychiatric conditions that may disadvantage female applicants. We also identified serious limitations in the availability of accurate VAC client data. These limitations made it impossible for us to measure the impact of the systemic sex-based biases we uncovered.

We found fairness issues in five key areas:

1. *2018 Disability Adjudication Directive Erectile Dysfunction Consequential to Psychiatric Conditions (Medication Use)* (VAC, 2018)
2. *PEN 68e Medical Questionnaire: Urinary, Sexual, Reproductive Conditions* (VAC, 2019c)
3. *Table of Disabilities* (VAC, 2006a)
4. *Psychiatric Entitlement Eligibility Guidelines* (VAC, 2016a; 2016b; 2016c; 2016d; 2016e; 2016f; 2016g; 2021)
5. Availability of VAC client data

In the following sections, we present our methodology, background information on sexual dysfunction and VAC adjudication processes, and our analysis of current research and VAC adjudication process and instruments. We then conclude with a summary of our findings and recommendations. Definitions for important terms are available in Annex A.

[2] Sexual dysfunctions are conditions relating to issues with sexual desire, arousal, orgasm and ejaculation, resolution, physical issues and/or pain (Montgomery, Baldwin, & Riley, 2002, 119-120; Serretti & Chiesa, 2009, p. 259; Baldwin, 2004, p. 457-458; Keks, Hope, & Culhane, 2014, p. 525).

[3] A consequential claim is a claim for a separate condition caused by a primary entitled service-related injury or disease (VAC, 2019b). An entitled condition is a condition that VAC has determined is related to service, which entitles the applicant to treatment benefits and possibly compensation for the condition.

VAC is already working to address some of the recommendations made in this report. In January 2022, VAC released a new Sexual Dysfunction *Entitlement Eligibility Guideline*, and there are plans to update the *Table of Disabilities* and the *PEN 68e Medical Questionnaire*. These updates are outside of the scope of this report because our investigation began before these changes were announced. We address the adjudication process as of November 2021, and footnote where new VAC initiatives may address the issues we identify. We hope this report can help guide some of these changes to ensure fairness for all Veterans with sexual dysfunction.

Methodology

Our report investigates the adjudication of sexual dysfunctions that are caused by entitled service-related psychiatric conditions or medications used to treat those conditions in Canadian Armed Forces (CAF) and Royal Canadian Mounted Police (RCMP) Veterans and members. This report does not investigate the adjudication of primary sexual dysfunction claims,[4] consequential conditions caused by non-psychiatric conditions or their treatment (e.g., sexual dysfunction caused by physical injuries or diseases), VAC treatment benefits for sexual dysfunction, nor does it look at sexual dysfunction unrelated to service. The scope of this report was limited to female sexual dysfunctions consequential to an entitled psychiatric condition. Male, trans, and nonbinary sexual dysfunctions other than erectile dysfunctions and female sexual dysfunctions were outside of scope. We recognize that these client groups deserve attention and hope that future research and policy initiatives will address fairness issues in the adjudication of sexual dysfunction in diverse populations.

Our primary research question was, "Is there sex-based bias in VAC adjudication processes for sexual dysfunction consequential to entitled psychiatric conditions?" To answer this question, we analyzed VAC adjudication instruments and processes, current academic literature, VAC and OVO client data, and Veterans Review and Appeal Board (VRAB) cases related to sexual dysfunction.

Information used in our analysis about VAC adjudication instruments and processes was obtained from and verified by VAC officials. We identified and reviewed all adjudication instruments used in the adjudication of sexual dysfunction consequential to an entitled psychiatric condition. We included four main adjudication instruments in our analysis:

- *2018 Disability Adjudication Directive Erectile Dysfunction Consequential to Psychiatric Conditions (Medication Use)* (VAC, 2018)
- *PEN 68e Medical Questionnaire: Urinary, Sexual, Reproductive Conditions* (VAC, 2019c)
- *Table of Disabilities* (VAC, 2006a)
- Psychiatric *Entitlement Eligibility Guidelines* (VAC, 2016a; 2016b; 2016c; 2016d; 2016e; 2016f; 2016g; 2021)

Background

[4] Primary sexual dysfunction claims are those that are not caused by another condition. Less than 30 claims of primary sexual dysfunction have been made at VAC in the last 5 years (VAC, email communication, July 15, 2021; July 22, 2021). While primary sexual dysfunction conditions were out of scope, the implementation of our recommendations would likely have a positive impact on Veterans who submit these claims.

Importance of sexuality

In a speech in 2001, over 20 years ago, the American Surgeon General highlighted the importance of sexuality, stating:

> Sexuality is an integral part of human life… it can foster intimacy and bonding as well as shared pleasure in our relationships. It fulfills a number of personal and social needs, and we value the sexual part of our being for the pleasures and benefits it affords us… sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. (Office of the Surgeon General, 2001, p. 1)

Being able to express oneself sexually, alone or with others, is a vital part of life that affects relationships, quality of life, and mental and physical health (Baldwin, 2004, p. 457; Levin, 2007).

What is sexual dysfunction

Sexual dysfunction is an umbrella term for conditions that manifest as a disruption in the sexual response cycle, such as a lack of sexual desire; issues with arousal, orgasm, ejaculation or resolution; and physical issues or pain (Serretti & Chiesa, 2009, p. 259). Often, people with sexual dysfunction experience disruptions in more than one part of the cycle (Baldwin, 2004, p. 458).

Mental, physical and comorbid health conditions, as well as decreases in health-related quality of life, can negatively affect sexual functioning (McIntyre-Smith, St. Cyr, & King, 2015). Sexual dysfunction can affect anyone throughout their lifetime, including single or partnered people, those not engaged in partnered sexual activity, cisgender women and men, transgender and non-binary people,[5] and heterosexual, lesbian, gay, bisexual, and other LGBTQ2+ people (Kerckhof et al., 2019; Laumann, Das, & Waite, 2008; Laumann, Paik, & Rosen, 1999; Peixoto & Nobre, 2014; Stark, Obedin-Maliver, & Shindel, 2021).

Two widely used contemporary classification and diagnostic systems that include psychiatric conditions and sexual dysfunction are the *International Classification of Diseases 11* (ICD-11) and the *Diagnostic and Statistical Manual 5* (DSM-5) (Hatzimouratidis & Hatzichristou, 2007). In both systems, sexual dysfunction has to meet several requirements to receive a diagnosis, including frequent occurrence, presence for a number of months, and "clinically significant distress" (WHO, 2019; APA, 2013). Both include male, female and non-sex-specific diagnoses, including erectile dysfunction, ejaculatory dysfunctions, desire and arousal dysfunctions, orgasmic dysfunctions, pain conditions and "other" sexual dysfunction categories. Individuals can have sexual issues that bother them but do not meet the diagnostic criteria for sexual dysfunction.

Sexual dysfunction is associated with negative outcomes for Veterans and people in the general population. These include increased suicidal ideation, medication non-adherence[6] and related mental illness relapse, relationship issues and breakdown, and significant reductions in mental health, self-esteem, well-being and

[5] For cisgender people, their assigned sex at birth matches their "internal gender identity" (e.g., a person assigned female at birth who also identifies as a woman), and for transgender people, their assigned sex at birth does not represent their internal gender identity (e.g., a person assigned female at birth who identifies as a man or is gender-nonconforming) (APA, 2020a; 2020b).

[6] Taking medication imperfectly or not at all against the advice of a physician, often to avoid side effects (Rothmore, 2020, p. 329).

overall quality of life (Blais, Monteith, & Kugler, 2018, p. 54; Khalifian et al., 2020, p. 1609; Labbate et al., 2008, p. 3; Rothmore, 2020, p. 329; Ashton et al., 2005; Williams et al., 2010; Nunnink, Fink, & Baker, 2012).

Sexual dysfunction, mental illness, and psychotropic medication

Mental illnesses, including schizophrenia, mood, personality, and anxiety disorders, and many medications that treat these conditions are risk factors for sexual dysfunction (Serretti & Chiesa, 2009, p. 259; Baldwin, 2004; Zemishlany & Weizman, 2008). Treatment-emergent sexual dysfunction can be caused by psychotropic medications, including antidepressants, anxiolytics, mood stabilizers and antipsychotics (Baldwin & Mayers, 2003; Healy, Le Noury, & Mangin, 2018; Castle, 2018, p. 2; Serretti & Chiesa, 2011).[7, 8]

Sexual dysfunction rates reported in academic literature vary widely, but antidepressant users have consistently been found to develop high rates of sexual dysfunction. For instance, the authors of three Spanish studies (Montejo-Gonzalez et al., 1997; Montejo et al., 2001; Montejo et al., 2019)[9] found that of patients taking antidepressants,[10] 58% to 80% developed sexual dysfunctions.

Research about rates of sexual dysfunction in male and female populations also differ in their conclusions. Some older studies found that females have higher rates (Laumann, Paik, & Rosen, 1999; Dunn, Croft, & Hackett, 1998; Angst, 1998), other research found that males do (Kikuchi et al. 2010; Turchik et al. 2012, p. 53), and some authors found no difference (Montejo et al., 2019).[11] In a study that found males and females were equally at risk of sexual dysfunction when taking antidepressants, higher risk was instead correlated with taking an antidepressant that works on serotonin and "having a severe clinical state of psychiatric illness" (Montejo et al., 2019, p. 926). In both groups, a loss of desire and delayed orgasm were the most common symptoms, but males were more likely to find their sexual dysfunction "intolerable" (Montejo et al., 2019, p. 930).

Males and females have been found to experience sexual dysfunction differently. For instance, a meta-analysis of treatment-emergent sexual dysfunction research found males have a significantly higher risk of disorders of desire and orgasm, whereas females were at a higher risk of disorders of arousal (Serretti & Chiesa, 2009, p. 262). Another study of treatment-emergent sexual dysfunction found that females were most likely to experience a "decrease in sexual desire" and males were most likely to have erectile dysfunction or ejaculatory conditions (Zemishlany & Weizman, 2008, p. 89).

Veterans and sexual dysfunction

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[7] Sexual dysfunction is most common with medications that affect serotonin, such as serotonin and norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors and some tricyclic antidepressants (Castle, 2018, p. 1). Almost all patients taking these medications "experience some degree of genital numbing, often within 30 minutes of taking the first dose" (Healy, Le Noury, & Mangin, 2018, p. 130).

[8] A list of types of psychotropic medications known to cause sexual dysfunction appears in Annex B.

[9] Researchers do not use consistent measures for sexual dysfunction, which leads to large variations in published rates (Reichenpfader et al., 2014, p. 11, 5). Some questionnaires such as the *Changes in Sexual Functioning Questionnaire* and the *Psychotropic-Related Sexual Dysfunction Questionnaire* generally report higher rates of sexual dysfunction, while "sexual effects scale and direct inquiry without any specific questionnaire are associated with lower percentages" (Serretti & Chiesa, 2009, p. 263).

[10] Mainly serotonin and norepinephrine reuptake inhibitors and selective serotonin reuptake inhibitors.

[11] Sexual dysfunction in female populations tends to be under-recognized and under-treated because there is a general lack of understanding of female sexual function and dysfunction (Parish et al., 2019; Parameshwaran & Chandra, 2019, p. 111). Research has also shown that females may be less likely to report their sexual dysfunction than males (Montejo et al., 2001, p. 15; Montejo et al., 2019). This could mean lower reported sexual dysfunction rates for female participants in some studies are due to under-recognition or under-reporting of sexual dysfunction in female populations more generally.

As of 2020, the estimated CAF and Canadian War Service Veteran population was 629,300, and about 133,200 Veterans were VAC clients, of whom 16,333 (12%) were female (VAC, 2020a). In total, 26% (34,765) of Veterans with disability benefits had a psychiatric-illness diagnosis, and of those, 71% (24,538) were diagnosed with PTSD (VAC, 2020a). In 2019-2020, PTSD was the most claimed condition for female Veterans and the third most claimed condition for male Veterans (VAC, 2020b).

Compared to their counterparts in the Canadian general population (CGP), male and female Veterans more often report "fair or poor" mental and physical health or suicidal ideation in their lifetime and are more at risk of having a diagnosed mood or anxiety disorder, including PTSD. Diagnosed anxiety and mood disorders are more common in female Veterans than male Veterans, which is also true in the CGP (Hall et al., 2020, p. 3).

Canadian research about sexual dysfunction and Veterans, and particularly female Veterans, is limited. A study of male treatment-seeking CAF members and Veterans with operational stress injuries found 21.5% of participants reported pain or other issues during intercourse and 41.8% reported issues with sexual desire or pleasure that "bothered [them] a lot" (Richardson et al., 2020, p. 71).[12] No studies of female Canadian Veterans and sexual dysfunction were found.

An American study of randomly selected Veterans using Veterans Affairs (VA) primary care found that approximately half screened positive for sexual dysfunction. Female Veterans were almost twice as likely as male Veterans (female = 62.3%, male = 32.0%) to have a sexual dysfunction (Shepardson et al., 2021, p. 361). Secondary research of the Veterans After-Discharge Longitudinal Registry (VALOR) cohort of Veterans' VA medical records found that approximately 25% of male and 13% of female Veteran participants had a diagnosed sexual dysfunction or were taking medications to treat a sexual dysfunction (Breyer et al., 2016). The numbers in this study are likely lower than those above that use self-report measures because the authors rely on VA medical records which have been found to under-report sexual dysfunction (Helmer et al., 2013, p. 1071).

Overview of VAC disability benefits adjudication instruments and processes

VAC disability benefits, including disability pensions, pain and suffering compensation, or both, compensate and provide treatment benefits and services to members and Veterans who have a permanent service-related injury or disease.[13]

VAC adjudication process for disability benefits[14]

The adjudication process for disability benefits claims generally occurs through a series of sequential steps:

- A client applies for benefits by submitting a Disability Benefits Application.

[12] Measured self-reported distress about sexual functioning using a Likert Scale.

[13] Pain and suffering compensation is provided under the *Veterans Well-being Act* for CAF members and Veterans. Disability pensions are provided under the *Pension Act* and apply mainly to RCMP members and Veterans and War Service Veterans (VAC COD, n.d.).

[14] A list of policy instruments used by adjudicators appears in Annex C.

- For less complex claims, a benefits program officer reviews the completed application and advises the applicant if more information is necessary. They may also adjudicate and prepare and send decision letters.
- More complex claims are referred instead to a disability adjudicator to adjudicate and prepare and send decision letters.
- Sometimes a disability adjudicator consults with medical advisors or other subject matter experts for clarification before a decision can be made. This step can cause lengthier wait times for decisions.
- For favourable decisions, a payment officer confirms the details of the application, verifies that the adjudicator's decision is correct according to the relevant legislation, and then calculates and authorizes payments (VAC COD, n.d.).

Favourable disability benefit decisions include two decisions: entitlement and assessment. First, the decision-maker determines whether the Veteran is entitled to the benefit, which grants the Veteran access to treatment benefits. Then, the assessment decision is rendered, which evaluates the impact of the condition and determines the amount of compensation, if any, a Veteran will receive.

Entitlement

The process of evaluating entitlement considers whether an applicant has a confirmed medical diagnosis for their claimed condition(s) and whether there is a relationship between their medical condition(s) and their service, meaning it was caused, partially caused, or aggravated by service or by another service-related condition.[15] If the condition is related to service or is the result of an entitled condition, full entitlement is granted. If the condition resulted from a non-service-related injury or disease that was aggravated by service, partial (four-fifths) entitlement is granted (VAC, 2019a). Disability benefit claims where the disability manifested during special duty service are granted full entitlement even if they are not directly related to service.[16]

To make these decisions, an adjudicator reviews information from the client's application, service health records, military service/personnel records, medical questionnaires and other medical reports, witness statements, the *Adjudication Manual* (VAC, 2019a), and *Entitlement Eligibility Guidelines* (EEGs) (VAC COD, n.d.). EEGs are policy statements used to help adjudicators determine an applicant's entitlement for benefits. There are currently 45 EEGs for the most commonly claimed conditions. The standard format of these EEGs can be found in Annex D. EEGs also contain instructions to help adjudicators determine whether to categorize conditions as primary, bracketed (with a primary condition) or consequential (to a primary condition):[17]

- **Primary**: a main claimed condition directly linked to service. Primary conditions can have bracketed and consequential conditions associated with them that may entitle the applicant to more compensation, treatment benefits, or both.
- **Bracketed:** these conditions are identified in Section B of an EEG. They are "entitled conditions which affect the same body areas or result in a similar loss of function and cannot be separated for medical

[15] These disabilities are covered under The Compensation Principle.
[16] These disabilities are covered under The Insurance Principle.
[17] A primary or consequential condition must be considered permanent. Bracketed conditions do not have this requirement.

assessment purposes, that are grouped or bracketed together to arrive at one Medical Impairment rating" (VAC, 2006b, p. 4).[18]

- **Consequential:** these conditions are identified in Section C of an EEG. Consequential conditions are caused by the primary condition and/or its treatment and affect a separate body part or system (VAC, 2019b).[19] For example, for an applicant with PTSD who has irritable bowel syndrome (IBS) caused by their PTSD, IBS would be consequential to the PTSD and would be adjudicated separately (VAC, 2016g, p. 9).

Assessment

Once entitlement has been determined, a disability adjudicator, benefits program officer, or medical advisor assesses the severity and impact of the condition using information from the client's application, service health records, medical questionnaires, medical reports, tests or other information from healthcare providers, the *Adjudication Manual* and the *Table of Disabilities* (TOD) (VAC COD, n.d.). This process determines the amount of compensation a Veteran will receive for their entitled disability.

The decision-maker first determines the medical impairment rating from the relevant TOD chapter. The TOD has 17 chapters that assess a person's degree of impairment and determine the appropriate level of disability benefits for specific ailments or body parts/systems (VAC, 2006a).[20] The *Medical Impairment Rating Tables* help adjudicators determine the severity of the disability.

Chapter 2 of the TOD helps the decision-maker assess the impact of the condition on the applicant's quality of life (QOL) with a scale from 1 to 3. This rating evaluates the effect of the condition on activities of independent living, recreational and community activities, and personal relationships. One QOL rating is determined for each entitled primary or consequential condition (VAC, 2006c).[21] Once the QOL rating is completed, it is combined with the medical impairment rating which is then expressed as a percentage (VAC COD, n.d.). This percentage reflects the degree of impairment and establishes the amount of compensation the Veteran will receive for their entitled condition.[22, 23]

For more on how disability benefits are calculated, detailed examples are provided in the introductory chapter of the TOD (VAC, 2006b).[24]

Analysis and findings

[18] The psychiatric EEGs include, in Section B, "Medical Conditions Which Are to Be Included in Entitlement/Assessment."

[19] Consequential conditions can be consequential to other consequential conditions as well. For clarity, we have chosen to refer to consequential claims as being related to primary conditions. Consequential conditions require their own separate entitlement decision and, if a favourable decision is made, the client receives treatment benefits and, depending on the condition, possibly additional compensation.

[20] The standard format of these TOD chapters can be found in Annex C.

[21] The three QOL levels identify the impact of the condition on the client.

[22] The last full revision of the TOD was in 2006 and ten of its chapters were updated between 2016 and 2019.

[23] A claim can be reassessed if the applicant can demonstrate that the condition has permanently worsened or provide medical information not included in the initial assessment.

[24] Everyone who has entitlement for a condition has the same access to treatment regardless of assessment level.

Our analysis focuses on the adjudication processes in place as of November 2021. We have made note where we understand that VAC may have or will update some elements of its adjudication processes related to sexual dysfunction.[25]

We found fairness issues in five areas:

1. *2018 Disability Adjudication Directive Erectile Dysfunction Consequential to Psychiatric Conditions (Medication Use)* (VAC, 2018)
2. *PEN 68e Medical Questionnaire: Urinary, Sexual, Reproductive Conditions* (VAC, 2019b)
3. *Table of Disabilities* (VAC, 2006a)
4. Psychiatric *Entitlement Eligibility Guidelines* (VAC, 2016a; 2016b; 2016c; 2016d; 2016e; 2016f; 2016g; 2021)
5. VAC client data

Overall, we found that the instruments and processes VAC uses to adjudicate sexual dysfunction claims consequential to an entitled psychiatric condition have a sex-based bias and may disadvantage female clients. We also identified serious limitations in the availability of accurate VAC client data. These limitations made it impossible for us to quantify how many Veterans may be impacted by the systemic sex-based biases we uncovered in the adjudication instruments. The issues with each instrument are described below, followed by recommendations to resolve them.

Finding 1: Sex-based bias in streamlined applications

The most common male sexual dysfunction applications consequential to entitled psychiatric conditions are streamlined. In 2018, VAC created the *Disability Adjudication Directive Erectile Dysfunction Consequential to Psychiatric Conditions (Medication Use)* which streamlines the adjudication of disability benefit claims for erectile dysfunction resulting from medication used to treat an entitled psychiatric condition (VAC, 2018). This directive allows disability adjudicators to make disability benefit decisions for this condition, whereas all other sexual dysfunction claims must be sent to a medical advisor for review, which may lengthen the wait time for decisions.[26] Effectively, this directive streamlines the most common sexual dysfunction condition experienced by male clients consequential to an entitled psychiatric condition, but no similar process was implemented for female claimants.[27]

[25] Ten weeks after we formally advised VAC that we were launching an investigation into the adjudication of sexual dysfunction claims consequential to entitled psychiatric conditions and their treatment, VAC advised that they would be creating and releasing a new EEG for sexual dysfunction in early-January 2022. The OVO received an advanced draft of this EEG and provided VAC with a list of questions in response in November 2021. Through this review process, we were informed that VAC also planned to update the relevant medical questionnaire, medical codes and the *2018 Disability Adjudication Directive Erectile Dysfunction Consequential to Psychiatric Conditions (Medication Use)*. The publication of our investigation follows the planned release of updates to the adjudication process; this was beyond our control and our timeline did not permit us to incorporate an assessment of the final updated documents or their implementation.

[26] Prior to 2018, all claims for sexual dysfunction, including erectile dysfunction, required a consultation with a VAC medical advisor.

[27] VAC provided us with a list of conditions requiring a medical advisor consultation, but it does not include any medical references or peer-reviewed research to explain why medical consultation is required for these conditions (OVO Secretariat, email communication, June 18, 2021). The list has not been updated since 2017, and does not specifically mention sexual dysfunction, but does refer to consequential conditions. It states that if an EEG is

While this was a positive initiative intended to improve the adjudication process for consequential erectile dysfunction claims, the unfair absence of a similar provision for other Veterans experiencing similar side effects from the treatment of entitled psychiatric conditions demonstrates the importance of conducting Gender-Based Analysis Plus (GBA Plus) on any new initiatives.[28] Many psychotropic medications are known to cause sexual dysfunctions in females and males, including sexual dysfunctions of desire, arousal and orgasm. Research is clear that these medications are associated with the development of female sexual dysfunctions, not just erectile dysfunction in males (Serretti & Chiesa, 2009; Montejo et al., 2019; Williams et al., 2010).

In summary, VAC streamlines applications for male Veterans with erectile dysfunction caused by medications to treat psychiatric conditions, but there is no equivalent process for sexual dysfunction applications by female Veterans. This is unfair because research has established a causal link between psychotropic medications and female sexual dysfunctions, which means that more females than males may be required to wait longer for compensation and access to treatment benefits for similar conditions. Therefore, the OVO recommends to the Minister of Veterans Affairs and Associate Minister of National Defence:

Recommendation 1: *Eliminate the sex-based bias in the VAC adjudication of sexual dysfunction claims consequential to a psychiatric condition. One way would be to use the same approach to decision-making for both male and female claims.*

Finding 2: Sex-based bias in the *PEN 68e Medical Questionnaire* used for sexual dysfunction claims

The *PEN 68e Medical Questionnaire: Urinary, Sexual, Reproductive Conditions* (VAC, 2019c)[29] is the VAC medical questionnaire used for primary or consequential claims of sexual dysfunction. The applicant's qualified medical practitioner lists and explains the applicant's diagnoses in a small blank text box on the questionnaire, which includes checklists as prompts.[30] There are separate physical examination checklists for males and females.

Our analysis found that this medical questionnaire is inherently male-biased because the checklist includes erectile dysfunction and ejaculatory pain, but no female-specific sexual dysfunctions (VAC, 2019a, pp. 2-3). For males, this questionnaire records the results of a physical examination of the testicles, penis, scrotum, prostate and breasts.[31] The checklist for females focuses on reproductive health by requesting information about the results of a physical examination of the ovaries, uterus, cervix/vagina, fallopian tubes and breasts. Unlike for

available and the consequential condition is not listed in Section C, a medical consultation is required. This applies to all sexual dysfunction conditions with erectile dysfunction being the exception.

[28] GBA Plus is a type of analysis using an intersectional approach to "assess how diverse groups of women, men, and gender diverse people may experience policies, programs and initiatives." In addition to sex and gender, GBA Plus also considers how intersecting identity factors "such as race, ethnicity, religion, age, and mental or physical disability" affect how individuals experience programs and policies (Women and Gender Equality Canada, 2021). The Prime Minister in his Supplementary Mandate Letter to the Minister of Veterans Affairs directed that VAC should integrate GBA Plus into policy and program development to eliminate gender bias and inequities in access to programs and services (Office of the Prime Minister, 2021).

[29] VAC advised that they plan to implement new medical questionnaires, one specifically male and the other specifically female, in early 2022. This questionnaire is planned to be updated again alongside the TOD.

[30] Each diagnosis requires information about whether it is "confirmed" or "provisional," if medical improvement is expected, and if so, an approximate expected timeframe for that improvement (VAC, 2019a, p. 1). A general medical history of the conditions is gathered, including symptoms, "frequency, duration, aggravating and relieving factors."

[31] This list also includes Peyronie's disease, a sexual dysfunction caused by a physical issue with the penis, which cannot be caused by a psychiatric condition or its treatment and therefore is outside the scope of this project.

males, the checklist for females offers no checkboxes for sexual dysfunctions such as female sexual interest/arousal disorder, female orgasmic disorder (anorgasmia) or genito-pelvic pain/penetration disorder (dyspareunia).[32] The *PEN 68e Medical Questionnaire* checklists can be found in Annex E.

We are concerned that the lack of female sexual dysfunctions on the questionnaire checklist may lead to less accurate and fewer confirmed sexual dysfunction diagnoses for female clients because, unlike for males, a qualified medical practitioner cannot simply check a box for female-specific conditions and instead must provide a diagnosis or describe the issue in a blank text box. When the diagnosed condition is not listed in the checklist, adjudicators and those with whom they consult are more likely to have to interpret that diagnosis. This may lead to greater instances of bracketing decreased libido with a psychiatric claim submitted by female clients (see Finding 4 below).[33]

The *PEN 68e Medical Questionnaire* used by a Veteran's qualified medical practitioner to document a confirmed diagnosis and describe symptoms of sexual dysfunction[34] contains a sex-based bias.[35] The *PEN 68e Medical Questionnaire* is aligned with the assessment criteria within Chapter 16 of the *Table of Disabilities* (TOD). This questionnaire contains a checklist that includes male sexual dysfunctions, but there is no checklist of female sexual dysfunctions. This means establishing a diagnosis for female sexual dysfunction is less straightforward. It is less likely female sexual dysfunctions will be accurately captured in the questionnaire, and when captured, it is more likely female conditions will be misunderstood than the most common male sexual dysfunctions.[36] Therefore, the OVO recommends to the Minister of Veterans Affairs and Associate Minister of National Defence:

Recommendation 2: ***Update the PEN 68e medical questionnaire to equitably capture sexual dysfunctions affecting all clients.***

Finding 3: Sex-based bias and lack of standardization for sexual dysfunction claims in the 2006 *Table of Disabilities*

The *Table of Disabilities* is used by VAC adjudicators to assess the level of impairment caused by an applicant's entitled condition(s). This assessment determines how much compensation a Veteran will receive for the condition. Chapter 16: *Urinary, Sexual and Reproductive Impairment* is the only chapter in the TOD that assesses sexual conditions (VAC, 2006d). It does so with two impairment rating tables: Table 16.3 *Loss of Function Sexual and Reproductive Male* and Table 16.4 *Loss of Function Sexual and Reproductive Female*.[37] The tables are focused on penetrative heterosexual intercourse and particularly on heterosexual males; they focus on male sex organs being able to penetrate and ejaculate and female sex organs being able to be penetrated. For instance, an impairment rating is only given for dyspareunia if it leads to a "persistent inability to participate in vaginal

[32] These conditions were included in the draft Sexual Dysfunction EEG that was shared with OVO.
[33] The bracketing of confirmed diagnoses of female sexual dysfunction as decreased libido, rather than as a consequential condition, is demonstrated in VRAB decisions (VRAB, 2016; 2017).
[34] A confirmed diagnosis is required to be entitled to or assessed for disability benefits.
[35] There is also a potential unfairness for male Veterans with sexual dysfunctions other than erectile dysfunction.
[36] Work to modernize the TOD is underway and VAC indicates it will use a GBA Plus lens to update assessment criteria and impairment ratings. VAC also advises that this work will include updating associated medical questionnaires.
[37] No references are used and no description or substantive information about sexual dysfunction is provided in Chapter 16.

intercourse" and only for ejaculatory pain if it causes "pain sufficient to cause total avoidance of intercourse" (VAC, 2006d, pp. 11-13). This suggests that the inability to penetrate or be penetrated is more disabling than any other kind of sexual dysfunction and ignores other types of sexual behaviours.

In both tables, sexual and reproductive issues are lumped into one category, penetrative intercourse is conflated with all sexuality and no attention is paid to sexual desire or pleasure, non-penetrative sex, masturbation or a female client's ability to experience orgasm. This represents a traditional, heteronormative view of sexuality, wherein male heterosexuality is privileged above all other forms of sexual expression, and it is assumed that all sex is penetrative intercourse occurring between a female and male, with males assumed to be active and females to be passive (Kiefer & Sanchez, 2007, p. 271).

Chapter 16 of the TOD reflects a lack of GBA Plus consideration, particularly around gender, sexual orientation and non-partnered sexual activity. Only three sexual dysfunction diagnoses are included in the TOD: two for males and one for females. Importantly, Tables 16.3 and 16.4 focus primarily on reproductive impairment rather than sexual function, reflecting a traditional gendered view of female bodies and male heterosexual sexuality.

Lack of Impairment Rating for Most Female Sexual Dysfunctions

While the TOD lists three diagnoses for sexual dysfunctions that can be consequential to entitled psychiatric conditions,[38] the *Diagnostic and Statistical Manual* (DSM-5) has 10 and the *International Classification of Diseases* (ICD-11) has 18 (See Annex F).[39, 40] This difference is mainly because the DSM-5 and ICD-11 include arousal, desire, female orgasmic and "other" sexual dysfunction categories, but the TOD only includes erectile dysfunction and severe post-ejaculatory pain for males and painful intercourse (dyspareunia) for females. This discrepancy means that the current version of the TOD does not include impairment ratings for sexual dysfunctions of desire or arousal for males and females, or orgasmic disorders for females.

An impairment rating is used along with a QOL rating to determine the level of compensation a client will receive. When there is no impairment rating table in the TOD, the claim is assessed on a case-by-case basis and a general assessment is used. A general assessment is less standardized than the assessment of conditions with set impairment ratings. There are no instructions provided in the TOD on how to assess claims when the medical impairment rating is not available. As noted in a 2018 VRAB decision, "[t]here is no general assessment table provided in the 2006 *Table of Disabilities*. The determination is arbitrary – although it is intended to be informed by medical expertise" (VRAB, 2018).

The lack of impairment ratings for sexual dysfunctions disproportionately impacts female Veterans, because every female sexual dysfunction other than painful intercourse is ignored. Although the TOD states that case-by-case assessment "should be fairly rare" (VAC, 2006b, p. 5), every case of female sexual dysfunction aside from painful intercourse follows this process.[41] The lack of impairment ratings for female conditions means that there is a lack of standardization in the assessment of sexual dysfunctions.

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[38] Erectile dysfunction and severe post-ejaculatory pain for males and dyspareunia (painful intercourse) for females.

[39] When counting specified and unspecified separately, as they do.

[40] A comparison of sexual dysfunctions in the TOD, DSM-5 and ICD-11 appears in Annex F.

[41] VAC says it plans to update the TOD in the coming years, but no timeframe for implementation has been announced.

Veterans who are dissatisfied with their benefit decision can appeal through the VRAB. Many VRAB decisions are published on the Canadian Legal Information Institute (CanLII) website. We reviewed decisions related to sexual dysfunction submitted by female Veterans. The decisions suggest that, in the absence of impairment ratings, the general assessment involves comparing female sexual dysfunction conditions to male sexual dysfunctions. For example, one VRAB decision explains that VAC assessed a woman's decreased libido using a general assessment and compared her condition to a male sexual dysfunction (erectile dysfunction, responsive to treatment) in the TOD to come up with an impairment rating. In this case, the client appealed the decision because she felt the impairment rating from this general assessment was not adequate. VRAB agreed and gave her a higher assessment, but it was still based on a comparison to a male condition (erectile dysfunction, unresponsive to treatment) (VRAB, 2014).

In summary, the TOD contains impairment ratings used to standardize the assessment of common conditions and the corresponding compensation amounts. There are two impairment ratings for male sexual dysfunctions and only one for female sexual dysfunctions. This means the process for deciding benefits for female sexual dysfunctions must be decided case-by-case more often than male claims, which may lead to inconsistent decisions and lengthier wait times. Fair process requires a clear provision of the decision-making criteria (OVO, 2021a). The VAC process for assessing sexual dysfunction claims is not standardized and does not include clearly defined decision-making criteria. The impairment ratings that do appear in the TOD privilege a traditional view of sexuality and thus privilege heterosexual penetrative sex and male sexuality, ignoring other types of sexual activities and female pleasure. Therefore, the OVO recommends to the Minister of Veterans Affairs and Associate Minister of National Defence:

Recommendation 3: *Update the Table of Disabilities to include impairment ratings for all sexual dysfunctions listed in contemporary diagnostic manuals to standardize the adjudication process for all clients.*

Finding 4: Adjudication of decreased libido is unclear and may lead to unfairness for female Veterans

Our analysis of the adjudication instruments indicates a lack of clarity about the use of decreased libido as a symptom bracketed with an entitled psychiatric condition. We are concerned that this lack of clarity may disproportionately negatively impact female clients.

When submitting a claim for sexual dysfunction related to an entitled psychiatric condition, adjudicators use the EEG for the client's psychiatric condition to determine if their sexual issues are to be bracketed (i.e., decreased libido) and included in the adjudication of the psychiatric condition or if they are to be consequential (i.e. sexual dysfunction) and need separate entitlement and assessment decisions. If the sexual issue is determined to be decreased libido, it is bracketed along with the entitled psychiatric condition. If it is determined to be consequential, a separate entitlement decision and assessment are required.[42]

VAC has eight EEGs used to adjudicate psychiatric conditions: adjustment disorder, alcohol use disorder, bipolar and related disorders, depressive disorders, generalized anxiety disorder, post-traumatic stress disorder,

[42] VAC will also use its recently implemented Sexual Dysfunction EEG to adjudicate sexual issues deemed to be sexual dysfunctions consequential to an entitled psychiatric condition.

substance use disorder and schizophrenia (VAC, 2016a; 2016b; 2016c; 2016d; 2016e; 2016f; 2016g; 2021). "Sexual dysfunction (e.g., erectile dysfunction)" appears as a consequential condition in five of the eight psychiatric EEGs,[43] chronic alcohol-induced sexual dysfunction appears in one[44] and two do not refer to sexual dysfunction at all.[45] Decreased libido appears as a bracketed symptom in Section B in all eight psychiatric EEGs and is the only symptom, rather than condition, listed.

This distinction between bracketed and consequential is important, because when a client is thought to have decreased libido (a bracketed symptom) the process of adjudication is much less clear than when they have a sexual dysfunction (a consequential condition). There are no clear guidelines for how to distinguish decreased libido and sexual dysfunction because there is no definition of decreased libido nor instructions on how to assess decreased libido in the TOD or any other adjudication instruments.

Throughout our investigation, we requested information from VAC to better understand the process of adjudicating decreased libido as a bracketed symptom/condition. We received conflicting information. Two emails from senior VAC medical experts confirmed that female sexual interest/arousal disorder and male hypoactive sexual desire disorder were adjudicated as a decreased libido.[46] The first email stated, "The conditions of female sexual interest and arousal disorder and male hypoactive sexual desire disorder are considered equivalent to loss of libido which is included in mental health conditions and many organic conditions."[47] After receiving this information, we asked VAC to confirm this information. In their response, VAC indicated that they "do not have an in-house definition for 'loss of libido'"[48] and confirmed this information by resending the original response verbatim.[49] Conversely, in its review of this report, VAC stated that these conditions are *not* considered decreased libido: "Sexual Interest/Arousal Disorders in males and females is considered a diagnosis with clinically significant symptoms which may include in addition to other symptoms, decreased libido."[50,51] The lack of clarity surrounding the definition and adjudication of decreased libido plagued us for the duration of this investigation. We attempted repeatedly to understand the process through information requests, follow-up clarification requests, and meetings with VAC experts. At each step, the answer was slightly different.[52]

This inability to clearly define and explain the adjudication process for decreased libido indicates that decision-makers have been without clear guidance, in stark contrast to the streamlined process for the most common male sexual dysfunctions. We are concerned that female sexual dysfunctions are more likely to be categorized as decreased libido and bracketed with entitled psychiatric conditions rather than adjudicated as consequential

[43] Adjustment disorder, bipolar and other related disorders, depressive disorders, generalized anxiety disorder and post-traumatic stress disorder.
[44] Alcohol use disorder.
[45] Substance use disorder and schizophrenia.
[46] As of November 2021.
[47] (VAC, email communication, June 28, 2021)
[48] (OVO Secretariat, email communication, September 29, 2021)
[49] "The conditions of female sexual interest and arousal disorder and male hypoactive sexual desire disorder are considered equivalent to loss of libido which is included in mental health conditions and many organic conditions." (VAC, email communication, June 28, 2021)
[50] (VAC Validation, email communication, January 7, 2022)
[51] This position was also taken by a VAC medical advisor we spoke with on August 30, 2021.
[52] Although the new Sexual Dysfunction EEG includes female sexual interest/arousal disorder and Male Hypoactive Sexual Disorder, the psychiatric EEGs have not been updated. Moreover, claims for these conditions submitted before 2022 may have been adjudicated as decreased libido (a symptom/condition not tracked by VAC, despite being listed in Section B of the eight psychiatric EEGs).

conditions because research has found that female sexual interest/arousal disorder[53, 54] is the most common sexual issue faced in the female population when taking or not taking antidepressants (Serretti & Chiesa, 2009, p. 262; Briken et al., 2020; Kingsberg & Woodard, 2015, p. 477). Without a clear definition of decreased libido, it is likely that female clients with diagnosed sexual dysfunctions are having them adjudicated as a bracketed symptom. To test our hypothesis, we requested sex-disaggregated data on the number of bracketed decreased libido claims; VAC was unable to provide any information about this type of claim due to limitations in their data collection and reporting capabilities.

It is possible that a lack of guidance on the adjudication of sexual dysfunction and a lack of checkboxes for female sexual dysfunctions in the *PEN 68e Medical Questionnaire* could contribute to lengthier wait times for female sexual dysfunction claims and those claims being misunderstood as decreased libido leading to unfair decisions. This is true for female more than male clients because erectile dysfunction, the most claimed male sexual dysfunction, is the only sexual dysfunction that is clearly delineated as being a consequential condition and is included in the medical questionnaire checklist. For instance, in a VRAB decision from 2017, a female client had a sexual interest/arousal disorder caused by PTSD, which was adjudicated as bracketed decreased libido. She and her advocate requested that her condition be adjudicated as a consequential sexual dysfunction rather than bracketed decreased libido because she had a confirmed diagnosis of a sexual dysfunction and sexual dysfunctions for males are considered consequential conditions. The VRAB panel stated, "Female sexual dysfunction is not addressed in the same manner as male sexual dysfunction" and referred her case back to the Minister "to be assessed separately" (VRAB, 2017).

In summary, the process for adjudicating decreased libido bracketed with a psychiatric condition is unclear. Female Veterans are more likely to experience desire and arousal disorders that VAC adjudicates as decreased libido;[55] however, decreased libido is not defined in the *Entitlement Eligibility Guidelines* for psychiatric conditions. This may lead to unfair outcomes and longer wait times for female Veterans. Therefore, the OVO recommends to the Minister of Veterans Affairs and Associate Minister of National Defence:

Recommendation 4: ***Provide clearer guidance for adjudicating female sexual dysfunction claims consequential to a psychiatric condition by defining decreased libido in the psychiatric Entitlement Eligibility Guidelines.***

Finding 5: Inadequate data collection and reporting

Due to the limited availability of VAC client data for male and female clients with entitled consequential sexual dysfunction conditions,[56] it was impossible for us to determine the number of female Veterans impacted by our findings. The Department uses the *Pension Disease Classification Manual* to categorize diagnoses for sexual dysfunction using medical pension codes, which are designed to determine treatment benefits rather than provide information for statistical analysis (VAC, 2020c). The only specific codes related to sexual dysfunction are for two conditions for male Veterans: erectile dysfunction and ejaculatory dysfunction. For all other male and

[53] Previously known as "hypoactive sexual desire" in the DSM-IV.
[54] Or other equivalent conditions including dysfunctions of desire or arousal by other names.
[55] As of November 2021.
[56] (OVO Secretariat, email communication, June 21, 2021)

female conditions of sexual dysfunction, VAC uses the code 62900 - Other Diseases of GU [Genitourinary] System. However, this code also includes conditions not specific to sexual dysfunction, such as urinary and reproductive issues.

VAC data is clear about how many male clients have consequential claims for erectile or ejaculatory dysfunction. As of March 2021, 3,903 male clients had entitlement for a sexual dysfunction: 3,267 for erectile dysfunction, 165 for ejaculatory dysfunction, and 649 for Other Diseases of the GU System. However, the number of female clients with an entitled sexual dysfunction condition is unclear because their claims are combined with all claims by female clients for reproductive or urinary conditions. As of March 2021, there were 166 female clients with claims assigned to the catch-all category Other Diseases of the GU. Without more granularity in the data collection, we have no way of knowing the actual number of female clients with an entitled sexual dysfunction condition.[57]

Additionally, VAC systems are unable to provide any data on how many Veterans have decreased libido because this information is not tracked. As noted above, we have concerns that female Veterans' sexual dysfunctions may be more likely to be considered decreased libido but we have no way to verify this concern.[58]

Lack of accurate and searchable data about diverse VAC client groups, which is necessary to conduct GBA Plus, creates challenges in identifying where improvements to processes and policies are required to ensure fair access to programs and services. For example, VAC is unable to determine accurate rates, the prevalence of condition types, gender of clients and the types of medications taken for sexual dysfunctions. Searchable, disaggregated data is necessary to identify trends and inequities among the diverse Veteran client population. Data limitations make it impossible for VAC to adequately understand the nature of sexual dysfunction claims submitted by all clients. Very little is known about clients with sexual dysfunction or decreased libido which hindered our ability to conduct a fulsome analysis. Importantly, we were unable to quantify, validate, or assess the impact of the sex-based biases we found in adjudication instruments. Therefore, the OVO recommends to the Minister of Veterans Affairs and Associate Minister of National Defence:

Recommendation 5: *Refine the granularity of the data collection system in order to fully capture the nature of sexual dysfunction claims, including for decreased libido, in the diverse VAC client population.*

Conclusion

Research demonstrates that psychiatric conditions and their treatment can lead to sexual dysfunction in male and female populations. Males and females experience sexual dysfunction differently; females are more likely to experience issues with sexual desire and arousal, and males are more likely to experience erectile and ejaculatory dysfunctions. While Canadian research into sexual dysfunction among Veterans is limited, a recent study of American Veterans found that females had much higher rates of sexual dysfunctions than their male counterparts (Shepardson et al., 2021).

[57] (OVO Secretariat, email communication, December 20, 2021)

[58] The data can tell us that the most claimed entitled psychiatric conditions for consequential erectile and ejaculatory sexual dysfunctions were PTSD, depressive disorders and anxiety disorders. This is similar for consequential conditions listed under the category Other Diseases of GU System, with PTSD being by far the most claimed.

Our analysis uncovered five fairness issues with the instruments VAC uses to adjudicate sexual dysfunction claims consequential to an entitled psychiatric condition, including limited VAC client data, which reveal a sex-based bias. This report echoes our 2018 report, *Meeting Expectations: Timely and Transparent Decisions for Canada's Ill and Injured Veterans,* where we found that female Veterans are not treated fairly, because they wait longer for disability benefit decisions than male Veterans (OVO, 2018). Although VAC could not provide us with accurate data on the wait times for sexual dysfunction claims, we suspect female clients with consequential sexual dysfunctions wait longer because their case requires a consultation with a medical advisor.

Unfortunately, we could not ascertain how female clients may be affected by the sex-based biases we found because of serious issues with VAC data collection and reporting. The VAC adjudication process determines whether or not a Veteran will have access to treatment benefits and compensation and has a direct impact on how long Veterans wait for those benefits. Inadequate client data means we do not know whether female Veterans wait longer, receive less compensation or have difficulties accessing treatment due to the sex-based biases we found. This issue is not new. We also found inadequate data collection and reporting in our 2021 report, *Peer Support for Veterans who have Experienced Military Sexual Trauma* (OVO, 2021b). We are concerned that, in general, these data issues are not limited to specific program areas but are endemic across programs.

Sexual dysfunction is an important issue, but many Veterans and other prospective or current VAC clients may not know that their sexual dysfunction could be related to their entitled psychiatric condition or that they may be eligible for treatment and/or compensation. Overall, our recommendations point to the need for VAC to update its adjudication instruments, including the *Table of Disabilities*, the psychiatric *Entitlement Eligibility Guidelines* and medical questionnaires, so that all clients experiencing sexual dysfunction conditions related to an entitled psychiatric condition are treated fairly. Female Veterans with a service-related sexual dysfunction should not have to wait longer or experience an unfair outcome simply because of their sex.[59]

Recommendations to the Minister of Veterans Affairs and Associate Minister of National Defence

1. Eliminate the sex-based bias in the VAC adjudication of sexual dysfunction claims consequential to a psychiatric condition. One way would be to use the same approach to decision-making for both male and female claims.
2. Update the *PEN 68e Medical Questionnaire* to equitably capture sexual dysfunctions affecting all clients.
3. Update the *Table of Disabilities* to include impairment ratings for all sexual dysfunctions listed in contemporary diagnostic manuals to standardize the adjudication process for all clients.
4. Provide clearer guidance for adjudicating female sexual dysfunction claims consequential to a psychiatric condition by defining decreased libido in the psychiatric *Entitlement Eligibility Guidelines*.

[59] The implementation of our recommendations would improve the process for those submitting a primary claim of sexual dysfunction as well as consequential or primary claims made by male, trans, and non-binary clients, and clients not engaged in partnered sexual activity.

5. Refine the granularity of the data collection system in order to fully capture the nature of sexual dysfunction claims, including for decreased libido, in the diverse VAC client population.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2020a). Cisgender. In *APA Dictionary of Psychology*. https://dictionary.apa.org/cisgender

American Psychological Association. (2020b). Transgender. In *APA Dictionary of Psychology*. https://dictionary.apa.org/transgender

Angst, J. (1998). Sexual problems in healthy and depressed persons. *International Clinical Psychopharmacology, 13*(Suppl 6), S1–S4. https://doi.org/10.1097/00004850-199807006-00001

Ashton, A. K., Jamerson, B. D., Weinstein, W. L., & Wagoner, C. (2005). Antidepressant-related adverse effects impacting treatment compliance: Results of a patient survey. *Current Therapeutic Research*, *66*(2), 96-106. https://doi.org/10.1016/j.curtheres.2005.04.006

Baldwin, D. S. (2004). Sexual dysfunction associated with antidepressant drugs. *Expert Opinion on Drug Safety, 3*(5), 457-470. https://doi.org/10.1517/14740338.3.5.457

Baldwin, D. S., & Mayers, A. (2003). Sexual side-effects of antidepressant and antipsychotic drugs. *Advances in Psychiatric Treatment, 9*(3), 202-210. https://doi.org/10.1192/apt.9.3.202

Blais, R. K., Monteith, L. L., & Kugler, J. (2018). Sexual dysfunction is associated with suicidal ideation in female service members and Veterans. *Journal of Affective Disorders*, *226*, 52-57. https://doi.org/10.1016/j.jad.2017.08.079

Breyer, B. N., Fang, S. C., Seal, K. H., Ranganathan, G., Marx, B. P., Keane, T. M., & Rosen, R. C. (2016). Sexual health in male and female Iraq and Afghanistan US war veterans with and without PTSD: Findings from the VALOR Cohort. *Journal of traumatic stress, 29*(3), 229-236. https://doi.org/10.1002/jts.22097

Briken, P., Matthiesen, S., Pietras, L., Wiessner, C., Klein, V., Reed, G. M., & Dekker, A. (2020). Estimating the prevalence of sexual dysfunction using the new ICD-11 guidelines: Results of the first representative, population-based German health and sexuality survey (GeSiD). *Deutsches Ärzteblatt International*, *117*(39), 653-658. https://doi.org/10.3238/arztebl.2020.0653

Castle, D. J. (2018). Sexual side-effects associated with antidepressants: A clinical guide. *HealthEd, Expert Monograph,* Issue 17. http://www.sol.com.au/delivery/healthed/monographs/Monograph%20%2317.pdf

Dunn, K. M., Croft, P. R., & Hackett, G. I. (1998). Sexual problems: A study of the prevalence and need for health care in the general population. *Family Practice*, *15*(6), 519-524. https://doi.org/10.1093/fampra/15.6.519

Hall A. L., Sweet J., Tweel M., MacLean M.B. Comparing negative health indicators in male and female Veterans with the Canadian general population. (2020). *BMJ Mil Health.* Advance online publication. https://doi.org/10.1136/bmjmilitary-2020-001526

Hatzimouratidis, K., & Hatzichristou, D. (2007). Sexual dysfunctions: Classifications and definitions. *The Journal of Sexual Medicine*, *4*(1), 241-250. https://doi.org/10.1111/j.1743-6109.2007.00409.x

Healy, D., Le Noury, J., & Mangin, D. (2018). Enduring sexual dysfunction after treatment with antidepressants, 5 α-reductase inhibitors and isotretinoin: 300 cases. *International Journal of Risk & Safety in Medicine*, *29*(3-4), 125-134. https://doi.org/10.3233/jrs-180744

Helmer, D. A., Beaulieu, G. R., Houlette, C., Latini, D., Goltz, H. H., Etienne, S., & Kauth, M. (2013). Assessment and documentation of sexual health issues of recent combat Veterans seeking VHA care. *The Journal of Sexual Medicine*, *10*(4), 1065-1073. https://doi.org/10.1111/jsm.12084

Johns Hopkins Medicine (2021b). *Mood disorders.* https://www.hopkinsmedicine.org/health/conditions-and-diseases/mood-disorders)

Johns Hopkins Medicine (2021c). *Schizophrenia.* https://www.hopkinsmedicine.org/health/conditions-and-diseases/schizophrenia

Johns Hopkins Medicine. (2021a). *Anxiety disorders.* https://www.hopkinsmedicine.org/health/conditions-and-diseases/anxiety-disorders

Keks, N. A., Hope, J., & Culhane, C. (2014). Management of antidepressant-induced sexual dysfunction. *Australasian Psychiatry*, *22*(6), 525-528. https://doi.org/10.1177/1039856214556323

Kerckhof M. E., Kreukels B. P. C., Nieder T. O., Becker-Hébly I., van de Grift T. C., Staphorsius A. S., Köhler A., Heylens G., & Elaut E. (2019). Prevalence of sexual dysfunctions in transgender persons: Results from the ENIGI follow-up study. *The Journal of Sexual Medicine*, *16*(12), 2018-2029. https://doi.org/10.1016/j.jsxm.2019.09.003

Khalifian, C. E., Knopp, K., Wilks, C. R., Wooldridge, J., Sohn, M. J., Thomas, D., & Morland, L. A. (2020). The association between sexual functioning and suicide risk in US military Veteran couples seeking treatment for post-traumatic stress disorder. *Archives of Sexual Behavior*, *49,* 1601-1613. https://doi.org/10.1007/s10508-019-01577-x

Kiefer, A. K., & Sanchez, D. T. (2007). Scripting sexual passivity: A gender role perspective. *Personal Relationships*, *14*(2), 269-290. https://doi.org/10.1111/j.1475-6811.2007.00154.x

Kikuchi, T., Uchida, H., Suzuki, T., Watanabe, K., & Kashima, H. (2011). Patients' attitudes toward side effects of antidepressants: An internet survey. *European Archives of Psychiatry and Clinical Neuroscience*, *261*(2), 103-109. https://doi.org/10.1007/s00406-010-0124-z

Kingsberg, S. A., & Woodard, T. (2015). Female sexual dysfunction: Focus on low desire. *Obstetrics & Gynecology, 125*(2), 477-486. https://doi.org/10.1097/aog.0000000000000620

Labbate, L. A., Grimes, J., Hiaes, A., Oleshansky, M. A., & Arana, G. W. (2008). Sexual dysfunction induced by serotonin reuptake antidepressants. *Journal of Sex & Marital Therapy*, *24*(1), 3-12. https://doi.org/10.1080/00926239808414663

Laumann, E. O., Das, A., & Waite, L. J. (2008). Sexual dysfunction among older adults: Prevalence and risk factors from a nationally representative US probability sample of men and women 57–85 years of age. *The Journal of Sexual Medicine*, *5*(10), 2300-2311. https://dx.doi.org/10.1111%2Fj.1743-6109.2008.00974.x

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association*, *281*(6), 537–544. https://doi.org/10.1001/jama.281.6.537

Levin, R. J. (2007). Sexual activity, health and well-being–the beneficial roles of coitus and masturbation. *Sexual and Relationship Therapy*, *22*(1), 135-148. https://doi.org/10.1080/14681990601149197

Lips, H. M. (2020). *Sex and gender: An introduction* (7th ed.). Waveland Press. https://www.waveland.com/browse.php?t=720

McIntyre-Smith, A., St. Cyr, K., & King, L. (2015). Sexual functioning among a cohort of treatment-seeking Canadian military personnel and Veterans with psychiatric conditions. *Military Medicine, 180*(7), 817-824. https://doi.org/10.7205/milmed-d-14-00125

Montejo A. L., Llorca G., Izquierdo J. A., & Rico-Villademoros F. (2001). Incidence of sexual dysfunction associated with antidepressant agents: A prospective multicenter study of 1022 outpatients. Spanish Working Group for the Study of Psychotropic-Related Sexual Dysfunction. *Journal of Clinical Psychiatry, 62*(Suppl 3), 10-21. https://doi.org/10.3410/f.718446934.793496193

Montejo, A. L., Calama, J., Rico-Villademoros, F., Montejo, L., González-García, N., & Pérez, J. (2019). A real-world study on antidepressant-associated sexual dysfunction in 2144 outpatients: The SALSEX I study. *Archives of Sexual Behavior*, *48*(3), 923-933. https://doi.org/10.1007/s10508-018-1365-6

Montejo-Gonzalez, A. L., Llorca, G., Izquierdo, J. A., Ledesma, A., Bousoño, M., Calcedo, A., Carrasco J. L., Ciudad J., Daniel E., De la Gandara J., Derecho J., Franco M., Gomez M. J., Macias J. A., Martin T., Perez V., Sanchez J. M., Sanchez S., & Vicens E. (1997). Fluoxetine, paroxetine, sertraline, and fluvoxamine in a prospective, multicenter, and descriptive clinical study of 344 patients. *Journal of Sex and Marital Therapy*, *23*(3), 176-194. https://doi.org/10.1080/00926239708403923

Montgomery, S. A., Baldwin, D. S., & Riley, A. (2002). Antidepressant medications: A review of the evidence for drug-induced sexual dysfunction. *Journal of Affective Disorders*, *69*(1-3), 119-140. https://doi.org/10.1016/S0165-0327(01)00313-5

Nunnink, S. E., Fink, D. S., & Baker, D. G. (2012). The impact of sexual functioning problems on mental well-being in US Veterans from the Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) conflicts. *International Journal of Sexual Health*, *24*(1), 14-25. http://dx.doi.org/10.1080/19317611.2011.639441

Office of the Prime Minister. (2021). *Minister of Veterans Affairs and Associate Minister of National Defence supplementary mandate letter*. Government of Canada. https://pm.gc.ca/en/mandate-letters/2021/01/15/minister-veterans-affairs-and-associate-minister-national-defence

Office of the Surgeon General (US). (2001). *The Surgeon General's call to action to promote sexual health and responsible sexual behavior.* Office of Population Affairs, United States Government. https://www.ncbi.nlm.nih.gov/books/NBK44216/

Office of the Veterans Ombud. (2018). *Meeting expectations: Timely and transparent decisions for Canada's ill and injured Veterans*. Veterans Affairs Canada, Government of Canada. https://www.ombudsman-veterans.gc.ca/en/publications/reports-reviews/timely-transparent-decisions

Office of the Veterans Ombud. (2021a). *Learn more.* Veterans Affairs Canada, Government of Canada. https://www.ombudsman-veterans.gc.ca/en/learn-more/our-approach

Office of the Veterans Ombud. (2021b). *Peer support for Veterans who have experienced military sexual trauma.* Veterans Affairs Canada, Government of Canada. https://www.ombudsman-

veterans.gc.ca/en/publications/reports-reviews/Peer-Support-for-Veterans-who-have-Experienced-Military-Sexual-Trauma

Parameshwaran, S., & Chandra, P. S. (2019). The new avatar of female sexual dysfunction in ICD-11—Will it herald a better future? *Journal of Psychosexual Health, 1*(2), 111-113. https://doi.org/10.1177/2631831819862408

Parish, S. J., Hahn, S. R., Goldstein, S. W., Giraldi, A., Kingsberg, S. A., Larkin, L., Minkin, M. J., Brown, V., Christiansen, K., Hartzell-Cushanick, R., Kelly-Jones, A., Rullo, J., Sadovsky, R., & Faubion, S. S. (2019). The International Society for the Study of Women's Sexual Health process of care for the identification of sexual concerns and problems in women. *Mayo Clinic Proceedings, 94*(5), 842-856. https://doi.org/10.1016/j.mayocp.2019.01.009

Peixoto, M. M., & Nobre, P. (2014). Dysfunctional sexual beliefs: A comparative study of heterosexual men and women, gay men, and lesbian women with and without sexual problems. *The Journal of Sexual Medicine*, *11*(11), 2690-2700. https://doi.org/10.1111/jsm.12666

Reichenpfader U., Gartlehner G., Morgan L. C., Greenblatt A., Nussbaumer B., Hansen R. A., Van Noord M., Lux L., & Gaynes B. N. (2014). Sexual dysfunction associated with second-generation antidepressants in patients with major depressive disorder: Results from a systematic review with network meta-analysis. *Drug Safety*, *37*(1), 19-31. http://dx.doi.org/10.1007/s40264-013-0129-4

Richardson, J. D., Ketcheson, F., King, L., Forchuk, C. A., Hunt, R., St. Cyr, K., Nazarov, A., Shnaider, P., McIntyre-Smith, A., & Elhai, J. D. (2020). Sexual dysfunction in male Canadian Armed Forces members and Veterans seeking mental health treatment. *Military Medicine*, *185*(1-2), 68-74. https://doi.org/10.1093/milmed/usz163

Rothmore, J. (2020). Antidepressant-induced sexual dysfunction. *Medical Journal of Australia*, *212*(7), 329-334. https://doi.org/10.5694/mja2.50522

Serretti, A., & Chiesa, A. (2009). Treatment-emergent sexual dysfunction related to antidepressants: a meta-analysis. *Journal of Clinical Psychopharmacology*, *29*(3), 259-266. https://doi.org/10.1097/JCP.0b013e3181a5233f

Serretti, A., & Chiesa, A. (2011). Sexual side effects of pharmacological treatment of psychiatric diseases. *Clinical Pharmacology & Therapeutics*, *89*(1), 142-147. https://doi.org/10.1038/clpt.2010.70

Shepardson, R. L., Mitzel, L. D., Trabold, N., Crane, C. A., Crasta, D., & Funderburk, J. S. (2021). Sexual dysfunction and preferences for discussing sexual health concerns among Veteran primary care patients. *The Journal of the American Board of Family Medicine*, *34*(2), 357-367. https://doi.org/10.3122/jabfm.2021.02.200326

Stark, B. A., Obedin-Maliver, J., & Shindel, A. W. (2021). Sexual wellness in cisgender lesbian, gay, and bisexual people. *Urologic Clinics of North America, 48*(4), 461-472. https://doi.org/10.1016/j.ucl.2021.06.005

Turchik, J. A., Pavao, J., Nazarian, D., Iqbal, S., McLean, C., & Kimerling, R. (2012). Sexually transmitted infections and sexual dysfunctions among newly returned Veterans with and without military sexual trauma. *International Journal of Sexual Health, 24*(1), 45-59. https://doi.org/10.1080/19317611.2011.639592

Veterans Affairs Canada Centralized Operations Division. (N.d.). *Introduction to disability benefits and adjudication*. Government of Canada. Internal VAC training: Unpublished

Veterans Affairs Canada. (2006a). *Table of disabilities.* Government of Canada. https://www.Veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/table-of-disabilities

Veterans Affairs Canada. (2006b). *Table of disabilities: Chapter 1 – Introduction.* Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/table-of-disabilities/ch-01-2006

Veterans Affairs Canada. (2006c). *Table of disabilities: Chapter 2 – Quality of life rating chapter.* Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/table-of-disabilities/ch-02-2006

Veterans Affairs Canada. (2006d). *Table of disabilities: Chapter 16 – Urinary, sexual and reproductive impairment.* Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/table-of-disabilities/ch-16-2006

Veterans Affairs Canada. (2016a). *Adjustment disorder entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/adj-dis

Veterans Affairs Canada. (2016b). *Alcohol use disorder entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/alcohol

Veterans Affairs Canada. (2016c). *Bipolar and related disorders entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/bipolar

Veterans Affairs Canada. (2016d). *Depressive disorders entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/depression-dis

Veterans Affairs Canada. (2016e). *Generalized anxiety disorder entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/anx-dis

Veterans Affairs Canada. (2016f). *Schizophrenia entitlement eligibility guideline.* Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/schiz

Veterans Affairs Canada. (2016g). *Posttraumatic stress disorder entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/ptsd

Veterans Affairs Canada. (2017). *Medical advisory / dental consultation list*. Government of Canada. Internal VAC document: Unpublished.

Veterans Affairs Canada. (2018). *Disability adjudication directive erectile dysfunction consequential to psychiatric conditions (medication use).* Government of Canada. Internal VAC directive: Unpublished.

Veterans Affairs Canada. (2019a). *Adjudication manual: Guidelines for adjudication of psychiatric claims*. Government of Canada. http://intranet.vac-acc.gc.ca/eng/operations/vs-toolbox/guidelines/guideline/2800

Veterans Affairs Canada. (2019b). *Consequential disability.* Government of Canada. https://www.veterans.gc.ca/eng/about-vac/legislation-policies/policies/document/1533

Veterans Affairs Canada. (2019c). *Medical questionnaire: Urinary, sexual, reproductive conditions (PEN 68e).* Government of Canada. https://www.veterans.gc.ca/eng/forms/document/73

Veterans Affairs Canada. (2020a). *Facts and figures*. Government of Canada. https://www.Veterans.gc.ca/pdf/about-vac/news-media/facts-figures/facts-and-figures-mar2020-1.pdf

Veterans Affairs Canada. (2020b). *Facts and figures table 4.9: Most common conditions – First applications completed by fiscal year.* Government of Canada. Internal VAC statistics report no. 2215: Unpublished.

Veterans Affairs Canada. (2020c). *Pension disease classification manual*. Government of Canada. Internal VAC Document: Unpublished.

Veterans Affairs Canada. (2021). *Substance use disorder entitlement eligibility guideline*. Government of Canada. https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/subst_use

Veterans Review and Appeal Board. (2014). 100002064914 (Re), 2014 CanLII 104191 (CA VRAB). https://canlii.ca/t/h6gd6

Veterans Review and Appeal Board. (2016). 100002504805 (Re), 2016 CanLII 39302 (CA VRAB). https://canlii.ca/t/gs998

Veterans Review and Appeal Board. (2017). 100003099144 (Re), 2017 CanLII 141719 (CA VRAB). https://canlii.ca/t/hrfhs

Veterans Review and Appeal Board. (2018). 100003361742 (Re), 2018 CanLII 78515 (CA VRAB). https://canlii.ca/t/htmgh

Williams, V. S. L., Edin, H. M., Hogue, S. L., Fehnel, S. E., & Baldwin, D. S. (2010). Prevalence and impact of antidepressant-associated sexual dysfunction in three European countries: Replication in a cross-sectional patient survey. *Journal of Psychopharmacology*, *24*(4), 489-496. https://doi.org/10.1177/0269881109102779

Women and Gender Equality Canada. (2021). *What is gender-based analysis plus?* Government of Canada. https://women-gender-equality.canada.ca/en/gender-based-analysis-plus/what-gender-based-analysis-plus.html

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Zemishlany, Z., & Weizman, A. (2008). The impact of mental illness on sexual dysfunction. *Sexual Dysfunction*, *29*, 89-106. https://doi.org/10.1159/000126626

Annexes

Annex A. Definitions of important terms

Disability adjudicator: a VAC employee who reviews applications for disability benefits to evaluate whether the applicant is eligible for benefits, and if so, the level of their disability and amount of compensation they are entitled to (VAC COD, n.d.).

Medical advisor: a VAC medical expert who provides guidance to adjudicators about entitlement to benefits and assessment of benefit amounts in complex or unclear cases.

Sexual dysfunction: Sexual dysfunction is an umbrella term for conditions that manifest as a disruption in the sexual response cycle, such as a lack of sexual desire; issues with arousal, orgasm, ejaculation, or resolution; or physical issues or pain (Serretti & Chiesa, 2009, p. 259). Often, people with sexual dysfunction experience disruptions in more than one part of the cycle (Baldwin, 2004, p. 458).

Primary condition: We use the term "primary condition" to refer to the main claimed condition(s) on an applicant's disability application. Primary conditions can have bracketed and consequential conditions associated with them that may entitle the applicant to more compensation, treatment benefits or both.

Bracketed condition: "entitled conditions which affect the same body areas or result in a similar loss of function and cannot be separated for medical assessment purposes, that are grouped or 'bracketed' together to arrive at one Medical Impairment rating" (VAC, 2006b, p. 4).

Consequential condition: a condition that is *caused* by the primary condition and/or its treatment that affects a separate body part or system. Consequential conditions require their own entitlement decision and assessment (VAC, 2019b).

Gender: Man, woman, trans and non-binary refer to gender, which speaks to the societal roles and expectations for what is considered masculine and feminine.

Sex: Male and female refer to biological sex, which is the sex assigned at birth (Lips, 2020, p. 7).

Annex B. Psychotropic medications associated with sexual dysfunction

Treatment-emergent sexual dysfunction can affect people taking psychotropic medications. Broadly, these medications are:

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and noradrenaline reuptake inhibitors (SNRIs)
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MOIs)
- Conventional antipsychotics
- Atypical antipsychotics (Baldwin & Mayers, 2003; Healy, Le Noury & Mangin, 2018, p. 125; Castle, 2018, p. 2; Serretti & Chiesa, 2010, pp. 144-145)

These drugs are used to treat psychiatric illnesses, such as:

- Mood disorders, including major depression and bipolar and related disorders (Johns Hopkins Medicine, 2021b)
- Anxiety disorders, such as post-traumatic stress disorder, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder and phobias (Johns Hopkins Medicine, 2021a)
- Schizophrenia (Johns Hopkins Medicine, 2021c)

Annex C. Policy instruments used to adjudicate disability benefits claims

The adjudication of disability benefits involves internal policy instruments and processes, including:

- Adjudication Manual (VAC, 2019a)
- Entitlement Eligibility Guidelines (EEGs)
- Evidence-Informed Decision Models
- Medical Guidelines
- Medical Questionnaires
- Table of Disabilities 2006 (TOD)
- Condition-Specific Directives[60]

Annex D. EEG and TOD chapter format

Each EEG follows a standard format:

- Definition
- Diagnostic Standard
- Anatomy and Physiology[61]
- Clinical Features[62]
- Entitlement Considerations[63]
    - Section A: "Causes and/or Aggravation"
    - Section B: "Medical Conditions to be Included in Entitlement/Assessment"
    - Section C: "Common Medical Conditions Which May Result in Whole or in Part from the Primary Condition and/or its Treatment"
- References (VAC, 2016a; 2016b; 2016c; 2016d; 2016e; 2016f; 2016g; 2021)

[60] Such as the *2018 Consequential ED Directive*
[61] Only included in EEGs for physical conditions.
[62] Only included in EEGs for physical conditions.
[63] Also referred to as "Pension Considerations" in some EEGs.

In Entitlement Considerations, each EEG lists bracketed conditions (symptoms of the primary condition) in Section B and consequential conditions (separate conditions *caused* by the primary condition) in Section C.

Each of the 17 TOD chapters for specific illnesses or body systems follows a standard format:

- Introductory section – describes the condition(s), relevant medical information and instructions on how to use the impairment tables in the chapter.
- Medical impairment tables – provide measurable criteria to assess functional loss and impairment caused by an entitled condition, measured from 0 to 100.
- Charts and diagrams – offer additional information to help with the interpretation of the medical impairment tables (VAC, 2006a).

Annex E. PEN 68e medical questionnaire checklist

Physical Examination - Female:

Please indicate the presence of any of the following (please check all that apply) within the appropriate category(ies):

Ovaries:

- ☐ tenderness/pain, specify: mild ◯ moderate ◯ severe ◯
- ☐ infertility at or after menopause
- ☐ pre-menopausal oophorectomy, specify: unilateral ◯ bilateral ◯
- ☐ pre-menopausal salpingectomy
- ☐ other, specify:

Comment:

Uterus:

- ☐ heavy irregular bleeding
- ☐ tenderness/pain, specify: mild ◯ moderate ◯ severe ◯
- ☐ masses
- ☐ hysterectomy, specify: pre-menopausal ◯ post-menopausal ◯
- ☐ endometriosis
- ☐ other, specify:

Comment:

Cervix/Vagina:

- ☐ vaginal fistulae
- ☐ other, specify:

Comment:

Fallopian Tubes:

- ☐ tubal ligation, elective
- ☐ loss of tubal patency, pre-menopausal

Comment:

Physical Examination - Female: (continued)

Breasts:

Comment:

- ☐ lumpectomy
- ☐ right mastectomy, specify: simple ◯ or radical ◯
- ☐ left mastectomy, specify: simple ◯ or radical ◯
- ☐ bilateral mastectomy, specify: simple ◯ or radical ◯
- ☐ other, specify:

Physical Examination - Male:

Testicles:

Comment:

- ☐ atrophy of 1 testicle, specify: right ◯ or left ◯
- ☐ loss of 1 testicle, specify: right ◯ or left ◯
- ☐ atrophy of bilateral testicles
- ☐ loss of bilateral testicles
- ☐ permanent sterility
- ☐ epididymitis
- ☐ other, specify:

Penis:

Comment:

- ☐ erectile dysfunction; responsive to treatment
- ☐ erectile dysfunction; unresponsive to treatment
- ☐ severe post-ejaculatory pain; total avoidance of intercourse
- ☐ removal of the glans penis
- ☐ loss of penis proximal to the glans
- ☐ peyronie's disease; capable of intercourse
- ☐ peyronie's disease; incapable of intercourse

Scrotum:

Comment:

- ☐ varicocele, with daily pain? Yes ◯ No ◯
- ☐ hydrocele, with daily pain? Yes ◯ No ◯
- ☐ other, specify: with daily pain? Yes ◯ No ◯

Prostate:

Comment:

- ☐ prostatitis
- ☐ benign prostatic hypertrophy
- ☐ epididymitis

Breasts:

Comment:

- ☐ lumpectomy
- ☐ gynecomastia
- ☐ persistent mammary discharge
- ☐ mastectomy, specify: unilateral ◯ bilateral ◯
- ☐ other, specify:

Annex F. Comparison of Sexual Dysfunction Diagnoses from the *TOD, DSM-5* and *ICD-11* by Gender

	Male	Female	General
TOD (2006)	Erectile dysfunction	Dyspareunia, with persistent inability to participate in vaginal intercourse	
	Severe post-ejaculatory pain sufficient to cause total avoidance of intercourse		
DSM-5 (APA 2013)	Erectile disorder	Female sexual interest/arousal disorder	Substance/medication-induced sexual dysfunction
	Male hypoactive sexual desire disorder	Female orgasmic disorder	Other specified sexual dysfunctions
	Premature ejaculation	Genito-pelvic pain/penetration disorder	Unspecified sexual dysfunction
	Delayed ejaculation		

ICD-11 (2020)	Male erectile dysfunction	Female sexual arousal dysfunction	Hypoactive sexual desire dysfunction
	Male early ejaculation	Sexual pain-penetration disorder	Anorgasmia
	Male delayed ejaculation		Other specified or unspecified sexual arousal dysfunctions
	Retrograde ejaculation		Other specified or unspecified orgasmic dysfunctions
	Other specified or unspecified ejaculatory dysfunctions		Other specified or unspecified sexual dysfunctions
			Other specified or unspecified sexual pain disorders

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