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Parents Served by Assertive Community Treatment: Parenting Needs, Services, and Attitudes

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Abstract

Objective—Assertive Community Treatment (ACT) is an evidence-based practice for individuals with severe mental illness. Although as many as half of all people with severe mental illness are parents, little is known about their experiences as parents and as recipients of mental health interventions, like ACT. The purpose of the current study was to examine the experiences of parent consumers served by ACT.

Methods—Seventeen parents being served by ACT teams were interviewed about parenting, parenting needs, severe mental illness, satisfaction with ACT services, and suggestions for improved parent-focused treatment services.

Results—All parents identified at least one positive aspect of parenting and most (77%) also identified negative aspects of parenting. Loss of custody emerged as a significant parenting problem, with most parents (88%) experiencing custody loss at least once. Parents expressed interest in numerous parent-focused services, including family therapy, parenting skills, communication skills training, resources for children, and peer support groups. Most participants with adult children reported having no unmet parent-related needs (88%) and high satisfaction (4.63 of 5) with ACT services, whereas parents with young children reported having several unmet parenting needs (78%) and relatively lower satisfaction (3.78 out of 5) with ACT services.

Conclusions and Implications for Practice—The ACT treatment model may not be adequately serving parents of young, dependent children. Findings suggest the need for more attention and focus on parent consumers, including identification of parental status and improved parent-related treatment services and support.

Keywords

Assertive Community Treatment Services; Severe Mental Illness; Parenting; Needs Assessment

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Assertive Community Treatment (ACT) provides intensive, community-based treatment for individuals with severe mental illness (SMI) with a history of extensive use of mental health services and difficulties in independent living (Bond, Drake, Mueser, & Latimer, 2001). ACT has been shown to be effective in reducing hospitalizations, and increasing community functioning and overall quality of life (Bond et al., 2001; McGrew, Bond, Dietzen, & McKasson, 1995). Although ACT effectively addresses many areas of community living, the challenges associated with being a parent are not typically addressed within the ACT treatment model. Consequently, ACT research has tended to ignore parental status as an important variable. Though studies have investigated the impact of different variables (e.g., age, substance use) on outcomes, no study has explicitly examined the potential impact of parenting on treatment outcomes with ACT (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007; Kortrijk, Mulder, Roosenschoon, & Wiersma, 2010).

Studies show that a large percentage of people with SMI are parents, suggesting that numerous ACT consumers are likely parents. In fact, data from the National Comorbidity Survey indicates that parenting rates for the SMI population are similar to the general population, with 66.8% of women and 58% of men with severe affective disorders and 61.8% of women and 55.2% of men with psychotic disorders being parents, compared to 62.4% of females and 52.9% of males without a psychiatric disorder being parents (Nicholson, Biebel, Katz-Leavy, & Williams, 2004). Currently, the precise number of ACT consumers who are parents is unknown. The only study to assess prevalence identified 38% of ACT consumers as parents; however, the estimate was based on only four small ACT teams in Canada (Gewurtz, Krupa, Eastabrook, & Horgan, 2004).

Because parenting tends to be overlooked as a critical area in the ACT model, ACT providers may be unaware of parental status of consumers and consumer needs in this area (Ackerson 2003; Gewurtz et al., 2004). This is problematic because parent consumers are a particularly vulnerable population and face many unique challenges and problems, tied to the dual demands of parenting and managing SMI (Ackerson 2003). For example, mothers with SMI are more likely to be divorced/separated, unemployed, and single mothers than mothers without mental illness and experience high levels of family strife, stigma, and victimization (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001; Nicholson, Sweeney, & Geller, 1998). Less than half of mothers with SMI receive child support or financial assistance from the other parent or a family member, and often raise their children below the poverty line (Mowbray et al., 2001). Moreover, mental illness symptoms and medication side effects sometimes impair abilities to support and care for children (Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998) often resulting in children having to take care of the family during the parent's acute episode(s) of SMI (Mechling, 2011).

Loss of custody is another serious problem. Parents with SMI are about three times more likely than healthy parents to experience child protective services involvement and/or custody loss, with an estimated 60% to 80% of parents with SMI losing custody of at least one child (Diaz-Caneja & Johnson, 2004; Kundra & Alexander, 2009). Parents with SMI also report feeling tremendous self-blame, shame and guilt regarding symptoms and relapses, causing them to question their parenting abilities, hide their SMI diagnosis, and feel unfairly judged as bad parents (Ackerson 2003; Diaz-Caneja & Johnson, 2004).

Although parents with SMI face difficult challenges, available treatment services do not adequately address these issues. When asked, parents express great interest in parent-related services, but report frustration with providers' failure to recognize the impact that being a parent has on mental illness and recovery (Ackerson 2003; Bournsnel 2007). They report wanting communication with providers about family issues and more emphasis on parenting in treatment planning and interventions (Diaz-Caneja & Johnson, 2004). This failure to

incorporate parenthood into treatment services is a missed opportunity because parents with SMI highly value their role as parents (Gerwurtz et al. 2004; Oyserman, Bybee, Mowbray, & Kyoung Kahng, 2004). They describe parenthood as a chance to feel successful and efficacious in a valued social role and a source of purpose in life, self-esteem, and motivation to adhere to treatment (Oyserman et al., 2004).

As noted above, ACT serves people with the most severe mental illnesses, many of whom are likely parents and in need of parent-related services and support. However, little information exists regarding the needs and experiences of parents served by ACT. Accordingly, the current study utilized structured interviews to examine the attitudes, thoughts, and experiences of parent consumers of ACT. Specific areas covered included the parenting role, custody, parenting needs, ACT parenting/family services, and suggestions for improved ACT services.

Method

Participants

To be included in the study, participants had to be enrolled on an Assertive Community Treatment team certified as meeting [State] Division of Mental Health and Addiction ACT standards, and the parent of at least one biological, adopted, or step child. Exclusion criteria included the presence of a cognitive disability that would interfere with the participant's ability to understand study questions, current inpatient hospitalization, or an active episode of acute psychiatric symptoms.

Recruitment

To generate the sample, team leaders of five ACT teams were contacted, informed about the purpose of the study, and asked to help with recruitment by posting and distributing recruitment flyers to potential participants. The five teams were selected from 16 ACT teams across the state to ensure inclusion of teams from different regions (e.g., northern vs. southern), settings (e.g., urban, rural, suburban), and consumer demographics (e.g., ethnicity, SES, gender). Three of the five team leaders agreed to aid in recruitment. Team leaders were asked to focus recruitment efforts on consumers judged to be psychiatrically stable and able to participate in the study. Recruitment materials instructed interested participants to contact the first author or inform the team leader of interest in the study. Interviews were scheduled either directly when participants contacted the first author or in coordination with the team leader.

Measure

A 50-item semi-structured interview was created for the study (available from first author), and informed by an interview guide for parents with SMI by Diaz-Caneja and Johnson (2004). Questions included nine general demographic items (e.g., date of birth, race/ethnicity, education, employment, living arrangement, and marital status), six items about mental health history (e.g., psychiatric diagnosis, age of diagnosis, inpatient hospitalization history, and substance abuse history), sixteen items about treatment services, and nineteen general parenting items. Four of the treatment services' items assessed previous and current use of services (e.g., time on ACT teams, types of services received from ACT team, use of non-ACT services) and 12 items assessed the treatment experience of being a parent consumer of ACT (e.g., discussions with providers about children, comfort of providers and consumers in addressing parenting issues and/or needs, parent-related services provided by ACT, suggestions for improved parent-related services). One item asked interviewees to rate their satisfaction with ACT parent-related services using a 5-point Likert-type scale (1=totally dissatisfied; 5= totally satisfied). The remaining parenting items included four

child-related demographic items (e.g., number of children, age, gender, biological/adopted), eight qualitative items about participant's role as parent (e.g., caregiving responsibilities, time spent with children, custody status), and seven qualitative items assessing attitudes and experiences (e.g., benefits of parenting, challenges of parenting, relationship between parenting and SMI, how children affect adherence to treatment, parenting needs). Four parenting items (e.g., other caregivers, aid from other caregivers) were dropped from the analyses because they assessed general aspects of parenting unrelated to the study's focus on the relationship between ACT services, SMI, and parenthood.

Procedure

The first author conducted all interviews individually with participants. Thirteen interviews were conducted in private office areas at the mental health agency and four interviews were conducted in the participant's home. To ensure privacy, other residents of the home were asked to leave the interview room. Prior to each interview, informed consent was obtained, including permission to tape record the interview. Participants were given a \$25 dollar gift card for participating.

The semi-structured questions guided the interviews. Pertinent follow-up and clarification questions were asked when necessary. In addition to tape recording, the first author took field notes regarding behavioral observations, nonverbal/facial cues, and unusual occurrences during the interview. After the interviews, participants were debriefed and provided contact information for future questions or concerns. The Institutional Review Board at [University] approved all study procedures.

Data Analysis

Interviews ranged from 35–92 minutes in length and were transcribed verbatim into a word processing document. The research team (i.e. primary researcher and two research assistants) reviewed transcribed interviews using a content analysis approach (Huberman & Miles, 1994) to identify preliminary emergent categories for open-ended questions. Next, each member of the research team independently analyzed the same transcribed interview using the preliminary categories. Coding discrepancies were identified, prompting revisions and a new round of coding analyzing a new interview. Four rounds of revisions took place, in which categories were eliminated, combined, or expanded, to best capture the data. The final set of codes was included in a final codebook, outlining the coding procedure for an entire interview. Overall, there were 143 categories for the qualitative items, ranging from four to eleven categories per question. Each category was treated as a separate dummy variable for data entry (0=category not present; 1=category present). Complex responses could be coded as satisfying more than one category.

To ensure reliability, all interviews were coded and analyzed by at least two members of the research team. Inter-rater reliability, as measured using the intraclass correlation (ICC), was acceptable for most of the categories coded, with values ranging from .23 to 1.00 (see Table 4 for ICC values for 7 items). Altogether, 120 of the 143 categories (84%) had good reliability with ICCs of .70 or higher and 13 categories (9%) had moderate reliability with ICCs of .60 or higher. Ten categories (7%) had poor reliability, including 5 indexed as "other" categories. When there were rating discrepancies, raters met and came to consensus. These consensus categories are reported below.

Results

Eleven female and six male parents with SMI participated. Participants were predominately female, Caucasian and divorced and reported having multiple diagnoses, the most common

being bipolar disorder (see Table 1). The average age of onset for mental illness was 27.5 years, with approximately 12.3 total hospitalizations per participant. Most were receiving disability benefits, with two parents (12%) employed part-time. Most participants (87%) had obtained a high school diploma or GED and roughly half lived alone in independent housing. Participants reported being served by ACT teams for a mean of 44.6 months (range: 3 months to 10 years).

Participants reported having 1 to 9 children, with an average of 2.6 children per participant (see Table 2). Altogether, participants had 44 children, ranging from 3–44 years of age. Most children (98%) were biological offspring and still living; one child was a stepchild and one child died at age 7 in a car accident. Only two participants were currently living with their children, although eight parents noted their adult children used to live with them when the children were younger. Across the 43 living children, 21 were adults living on their own, 10 were young children living with the other parent, 5 were young children living with the participant, 5 were young children living with an adoptive/foster family, and 2 were young children living with other relatives. In addition, 8 participants (47%) reported having grandchildren, ranging from 1–21 years of age (see Table 2). Grandparents in the sample had between 1 and 7 grandchildren, averaging 1.6 grandchildren per participant.

Contact/Custody

Four participants (24%) reported having no current contact with their children, with two participants (12%) seeing their children several times a year and eleven participants (65%) seeing their children at least once a month (see Table 3). Custody problems, particularly loss of custody, were common occurrences for most participants. At the time of the interviews, only two parents had full custody of any of their children, although both had lost custody in the past. Two additional parents reported previously having full custody of their now adult children, when the children were under 18 years. In total, fifteen parents (88%) lost or gave up custody of their children, with only 4 (24%) parents successfully regaining custody. In addition, most parents (82%) described their experiences with custody negatively, using adjectives like “painful,” “traumatic” or “world-shattering” (see Table 4). Specifically, participants talked about struggles with separating from children and/or harming the relationship with children (82%), the legal process (29%) feeling confused/ignored, (23%), giving up children for adoption (18%), fighting to get custody back (18%), and other issues.

Parent Attitudes

Every participant expressed positive attitudes about being a parent, emphasizing the benefits and joys of parenting. Specifically, 9 parents (53%) mentioned the love given and received by children, 6 (35%) discussed spending quality time with children, and 4 (24%) parents each talked about raising or teaching children, watching children grow up, strong relationships with their children, and other benefits (e.g., having someone to brag about, being proud, etc) (see Table 4). At the same time, 13 participants (77%) acknowledged difficulties with being a parent while managing mental illness, such as parenting/financial responsibilities (76%), separation from children and/or seeing child in pain (35%), punishment/discipline (17%), getting along with the other parent (17%), and other issues (e.g., helping with school, disagreements).

When asked about the potential relationship between being a parent and having SMI, three participants (18%) rejected the possibility, stating that one does not affect the other. The remaining participants generally endorsed the belief that SMI negatively impacts parenting, reporting problems associated with volatile mood/symptoms (47%), concern about the children’s view of their mental health (47%), medication side effects (29%), additional stress and worry caused by SMI (23%), and several other concerns (see Table 4). Regarding

the alternative relationship of how being a parent potentially impacts mental health, six participants (35%) denied that parenting has any impact on mental health. Other parents identified several potential impacts, including exacerbated symptoms (36%), changed relationship with children (29%), additional stress or worry (18%), source for motivation (12%), and a few other impacts. Lastly, participants were asked whether being a parent influences their interest in/commitment to treatment services. While five participants (30%) indicated no relationship, other participants cited their parental status as a great source of motivation (35%), as well as the primary reason for seeking treatment (23%)

Treatment Needs and Satisfaction with Services

Participants reported a wide variety of treatment services provided by ACT, including help with medication (82%), finances/ payeeship (77%), case management (71%), therapy/ counseling (71%), and transportation (65%); however, none listed family services as part of their treatment. When asked about parenting needs, about half reported no significant parenting needs at the time of the interview (see Table 4). The remaining parents reported several needs, including family therapy (41%), finances/resources for children (35%), communication with children (29%), social and emotional support from other parents (24%), and other needs (24%) (e.g., transportation to see children, liaison between participant and adoptive family).

Parents also expressed overall satisfaction with ACT in addressing parenting needs, giving a mean rating of 3.94 out of 5 ($SD=.90$), with 12 participants either satisfied or highly satisfied. When asked to explain their ratings, about half (53%) noted positive aspects of the team, such as “they help me with my children” or “she praises me when I visit with my children.” In contrast, seven participants (43%) noted negative aspects of the ACT team, such as “you would think I could tell them about it, but I can’t” and “they’ve never like ever tried to even go there period with me.”

To help understand these differences, comparisons were made between the 8 parents (47%) with adult children and 9 parents (53%) with children under the age of 18. Only 1 of 8 parents of adult children (13%) reported unmet parenting needs, whereas 7 of 9 parents of minor children (78%) reported unmet needs. This difference was statistically significant, $\chi^2(1) = 7.244$, $p = .007$, indicating that parents of young children reported more unmet needs. However, parents of adult ($M=4.12$, $SD=.84$) and minor children ($M=3.78$, $SD=.97$) were equally satisfied with ACT services ($t = -0.79$, $p = .45$).

Participant Suggestions

Eight participants identified parent-related issues or needs that ACT teams should consider incorporating into treatment services (see Table 4). Specifically, participants said ACT providers should focus on communication/bonding with children (35%), family therapy (35%), resources for children (35%), transportation to visit children (35%), custody issues (18%), social skills (18%), activities to do with children (18%), and other parenting needs. (e.g., schoolwork, housing, financial). Altogether, most participants (77%) reported being comfortable with making suggestions to ACT team members and several participants (18%) mentioned their intentions to talk to ACT providers about topics discussed in the interviews.

Discussion

The perspectives of the ACT parents interviewed for the study support previous findings regarding the unique needs, challenges, and experiences of parents with severe mental illness. Compared to parents without SMI, consumers with SMI face higher rates of divorce, lack of social support, unemployment, poverty, and single parent status (Mowbray et al.,

2001; Nicholson et al., 1998), all of which were found in the study. Of the 17 ACT parents interviewed, only 2 were in a relationship with a significant other or had part-time jobs, and most reported financial difficulties and general dissatisfaction with lack of available peer support. As expected, legal issues and loss of custody emerged as a significant challenge for ACT parents. Consistent with other studies estimating as many as 60%–80% of parents with SMI lose custody of their children (Diaz-Caneja & Johnson, 2004; Kundra & Alexander, 2009), 15 parents (88%) in the current sample reported losing custody at least once, and only one of the six fathers and one of the eleven mothers had primary custody at the time of the interviews. ACT parents expressed negative attitudes about these custody problems, emphasizing how traumatic and painful the experiences were, how custody loss damaged their relationship with their children, and increased feelings of shame and frustration. Further, over half of the participants complained about lack of child support from the other parent and/or family members, as well as the stress of providing for children without adequate financial resources. Such findings highlight the potential importance of addressing child custody in treatment and supporting parents faced with custody issues.

Consistent with prior qualitative studies, ACT parents hold both positive and negative attitudes regarding parenting (Boursnell 2007; Diaz-Caneja & Johnson, 2004). Every parent was able to identify at least one parenting benefit and several credited their role as parent as a reason and motivation to adhere to treatment. At the same time, most parents acknowledged the difficulties of being a parent with SMI, reported how SMI can negatively impact parenting, due to symptoms, medication side effects, stress associated with treatment, and concern about children's disapproving views of mental illness.

When exploring the effectiveness of ACT services for parent consumers, results were mixed. About half of participants reported no significant unmet parenting needs and reported general satisfaction with ACT services. Given the challenges participants discussed about being a parent with SMI, as well as prior research indicating many unmet needs of parents with SMI, these findings were unexpected (Ackerson 2003; Boursnell 2007). However, parenting needs appeared to vary greatly, depending on the age of participants' children. Although parents of adult children rarely reported unmet needs (13%), most parents with young children (78%) did report unmet parenting needs. The notable asymmetry suggests that parents of adult children likely have fewer needs because they no longer face the serious parenting challenges common to parents of young, dependent children, such as providing housing, food, transportation, clothing, school assistance, etc. In contrast, parents of young children have many significant needs that ACT services are not adequately addressing.

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Implications for Practice

Overall, this small study shows that despite a favorable caseload ratio, high intensity of services, and availability of a team of providers that include both medical and social service experts, ACT teams are not consistently addressing the mental health and community support needs of all parent consumers, especially parents of young, dependent children. Although these results are preliminary, some possible helpful action steps can be suggested. First, ACT providers should consider and include the parental status of parents with minor children in treatment planning. That is, teams should be aware of consumers who are parents, assess whether they have unmet parenting needs, and incorporate services addressing those needs, such as custody, communication/bonding with children, parenting skills, resources for children, and peer support. In addition, findings suggest a bidirectional relationship between mental health concerns and parenting issues; that is, illness management needs and parenting needs are intertwined and may need to be addressed together. Providers may wish to develop programs that address both types of needs, possibly via the suggestions made by participants, including family-based therapy, parenting skills training, lessons for communicating with children, and support groups with other parents with SMI. Although research will be needed to examine how these additional services may impact clinical outcomes, it is hoped that incorporating these changes into treatment will result in improved outcomes for parents with severe mental illness and their children.

Table 1**Participant Demographics**

Variable	Parents (N=17) Frequency (%)
Mean Age (SD)	47.9 (9.3)
Gender	
Female	11 (63.7%)
Male	6 (35.3%)
Race	
Caucasian	12 (70.6%)
Multiple Races	3 (17.6%)
Asian	2 (11.8%)
African American	1 (5.9%)
American Indian/Pacific Islander	1 (5.9%)
Hispanic	2 (11.8%)
Marital Status	
Divorced	11 (64.7%)
Single	5 (29.9%)
Relationship	2 (11.8%)
Widowed	1 (5.9%)
Married	0 (0%)
Mental Illness Diagnosis	
Bipolar Disorder	10 (58.8%)
Schizophrenia	7 (41.2%)
Schizoaffective	3 (17.6%)
Personality Disorder	2 (11.8%)
Total Hospitalizations	12.3 (18.4)
Mean Months (SD) Since Hospitalization	32.6 (41.5)
Months Since Joining ACT	44.6 (33.7)
Education	
HS Diploma/GED	7 (41.2%)
Some College	5 (29.4%)
No Diploma/GED	4 (23.5%)
Vocational Training Certificate	1 (5.9%)
Employment	
Disability/Benefits	11 (64.7%)
Unemployed	3 (17.6%)
Part-Time	2 (11.8%)
Volunteer	1 (5.9%)
Living Arrangement	
Independent Living	9 (52.9%)
Supervised Apartment Program	5 (29.4%)
Living with Relatives/Group Home	3 (17.6%)

Table 2

Participants' Children and Grandchildren

Variable	Frequency (%) Mean (SD)
Participants with Only Minor Children (N=17)	6 (35.3%)
With Minor and Adult Children	3 (17.6%)
With Adult Children Only	8 (47.1%)
Total Number of Children *	44
Number of Children per Participant	2.6 (1.94)
Age of Children (N=43) **	22.2 (12.3)
Minor Children (under age 18)	22 (51.2%)
Adult Children	21 (48.8%)
Relationship of Children (N=44) *	
Biological	43 (97.7%)
Adopted/Foster	1 (2.3%)
Residence of Children (N=43) **	
Child is Adult	21 (48.8%)
Other Parent	10 (23.3%)
With Participant	5 (11.6%)
Adoptive/Foster family	5 (11.6%)
Other Family Member	2 (4.7%)
Participants with Grandchildren (N=17)	8 (47.1%)
Total Number of Grandchildren	25
Number per Participant (N=25)	1.6
Age of Grandchildren	7.5 (6.9)
Participants Living with Grandchildren	0 (0%)

Note.

* N=44 (Includes one deceased child)

** N=43 (Excludes deceased child)

Table 3**Contact/Custody of Children**

Variable	Parents (N=17) Frequency (%)	Children (N=43) Frequency (%)
Participant Contact with Children		
None	4 (23.5%)	10 (23.3%)
Several (1–6) Times a Year	2 (11.8%)	10 (23.3%)
Once a Month	2 (11.8%)	5 (11.3%)
Several Times a Month	3 (17.6%)	10 (23.3%)
Once a Week or More	4 (23.5%)	3 (7.0%)
Everyday	2 (11.8%)	5 (11.6%)
Custody of Children		
Full Custody	2 (11.8%)	6 (13.9%)
Partial Custody	2 (11.8%)	3 (7.0%)
No Custody/No contact	2 (11.8%)	10 (23.3%)
Adoption/Foster family	3 (17.6%)	4 (9.3%)
Children are Adults (Had Custody)	2 (11.8%)	4 (9.3%)
Children are Adults (No Custody)	6 (35.3%)	16 (37.1%)
Custody Loss		
Retained Full Custody	2 (11.8%)	11 (25.6%)
Retained Partial Custody	3 (17.6%)	8 (18.6%)
Lost custody – Got it Back	2 (11.8%)	7 (16.3%)
Lost custody – Permanently	5 (29.4%)	11 (25.6%)
Adoption	4 (23.5%)	6 (14.0%)

Table 4

Participants' Experiences and Attitudes

Categories	Frequency (%) N=17	Inter-rater reliability
Experiences with Custody		
Painful/Traumatic	14 (82.4%)	.857
Separation/Affected Relationship	14 (82.4%)	.618
Legal Problems	5 (29.4%)	.746
Confusing	4 (23.5%)	.533
Gave up Custody	3 (17.6%)	.830
Fought to Get Back Custody	3 (17.6%)	.912
Always Had Custody	3 (17.6%)	1.00
No Answer/Other	2 (11.8%)	.828
Good Parts of Parenting	-	
Love - Given and/or Received	9 (52.9%)	1.00
Spending Time with Children	6 (35.3%)	1.00
Raising/Teaching Children	4 (23.5%)	1.00
Watching Children Grow Up	4 (23.5%)	.830
Relationship with Children	4 (23.5%)	.634
Spoiling/Giving Gifts	2 (11.8%)	1.00
Effect Children's Lives	2 (11.8%)	1.00
Other	4 (23.5%)	.444
Hard Parts of Parenting		
Responsibilities/Finances	13 (76.5%)	.621
Separation from Children/Child in Pain	6 (35.3%)	.566
Punishment/Discipline	3 (17.6%)	1.00
No Challenges	4 (23.5%)	1.00
Getting Along with Other Parent/Family	3 (17.6%)	1.00
Other	5 (29.4%)	.755
Mental Illness Impacts Parenting		
Mood/Symptoms	8 (47.1%)	.887
Children's View of Parent	8 (47.1%)	.632
Medication Side Effects	5 (29.4%)	.458
Added Stress/Worry	4 (23.5%)	.830
No Concern about Impact	3 (17.6%)	1.00
Other	3 (17.6%)	.230
Parenting Impacts Mental Illness		
No Impact	7 (41.1%)	.863
Symptoms	6 (35.3%)	.873
Relationship with Children	5 (29.4%)	1.00
Added Stress/Problems	3 (17.6%)	.774
Motivation	2 (11.8%)	.873
No Answer/Other	5 (29.4%)	.522

Categories	Frequency (%) N=17	Inter-rater reliability
Parenting Impacts Treatment		
Source of Motivation	6 (35.3%)	.822
No Impact	5 (29.4%)	.854
Reason for Therapy/Counseling	4 (23.5%)	.828
Don't Need Treatment	2 (11.8%)	.651
Other	3 (17.6%)	.776
Parenting Needs		
Family Services/Therapy	7 (41.2%)	.880
Have No Needs	7 (41.2%)	1.00
Financial/Resources	6 (35.3%)	.882
Better Communication with Children	5 (29.4%)	.857
Support (Emotional, Social)	4 (23.5%)	.634
Don't Know/Never Had Custody	4 (23.5%)	.483
Custody Assistance	3 (17.6%)	1.00
Other	4 (23.5%)	.857