CareCertify LLC

MH Rehabilitation Worker Core

MHW-01

Mental Illnesses in Rehabilitation Practice

Participant Guide

Audience: MH Rehabilitation Workers · Behavioral Aides · Behavioral Health Practitioners

Updated July 2026 — meets Minn. Stat. 245I.05, subd. 3(c)(1) initial training

See clearly, describe honestly, support fully

Mental Illnesses in Rehabilitation Practice opens the CareCertify MH Rehabilitation Worker Core — a four-lesson series that delivers the heart of the 30-hour pre-service training Minnesota requires for mental health rehabilitation workers, mental health behavioral aides, and behavioral health practitioners under Minn. Stat. 245I.05, subd. 3(c). This lesson covers the first required topic: mental illnesses.

Learning Objectives — by the end of this module you will be able to:

- Explain the mental health rehabilitation worker role and its supervision
- Describe the major mental illnesses you'll encounter and their common signs
- Recognize distress and decompensation early — and respond within your role
- Distinguish observing and describing from diagnosing
- Support clients in distress and know when to escalate
- Use person-first, recovery-oriented language about mental illness

Section 1: The rehabilitation worker's role

You build skills and support recovery — under supervision, within a plan.

- **Rehabilitative services.** You help adults build the skills to manage their illness and live the life they choose — per the client's treatment plan.
- **Always supervised.** You work under the treatment supervision of a mental health professional or certified rehabilitation specialist.
- **Not a diagnostician.** You don't diagnose or prescribe. You observe, support, teach skills, and report what you see to the team.
- **Why this training.** Minnesota requires 30 hours of training before you provide direct services — this series delivers the core of it.

Section 2: What mental illness is

Real health conditions — not weakness, not choice.

- **Health conditions.** Mental illnesses are medical conditions affecting mood, thinking, and behavior — treatable, and often manageable long-term.
- **They vary widely.** Symptoms range from mild to severe and change over time. The same diagnosis looks different in different people.
- **Recovery is real.** With treatment, support, and skill-building, people manage symptoms and build meaningful lives. That's your work.

Section 3: Depression and anxiety

The most common conditions you'll support.

- **Depression.** Persistent sadness, loss of interest, low energy, sleep and appetite changes, hopelessness, and trouble concentrating.
- **Anxiety.** Excessive worry, restlessness, racing heart, and avoidance. Panic attacks can feel like a medical emergency.
- **What you notice.** Withdrawal, missed goals, or talk of hopelessness. Any mention of suicide is reported immediately — never kept secret.

Depression can look like 'low motivation' and anxiety like 'resistance' — respond to the illness, not the label.

Section 4: Bipolar disorder

Cycles of mood that swing beyond ordinary ups and downs.

- **Depressive episodes.** The same low mood, low energy, and hopelessness seen in depression — sometimes the majority of the illness.
- **Manic episodes.** Elevated or irritable mood, little need for sleep, fast speech, big plans, and risky decisions.
- **Function shifts.** Watch for sudden changes in sleep, spending, energy, or goals between your visits — describe what changed.
- **Steadiness helps.** Consistent routines, medication support, and calm structure help. Report big swings to the team promptly.

Section 5: Psychotic disorders

When thinking and perception lose touch with shared reality.

- **Hallucinations.** Sensing things others don't — often hearing voices. They feel completely real to the person.
- **Delusions.** Fixed beliefs that aren't shared or supported by evidence — arguing rarely helps and often escalates.
- **Schizophrenia.** A condition that can include hallucinations, delusions, disorganized thinking, and reduced motivation or expression.
- **How you respond.** Stay calm, don't argue the content, focus on safety and the person's feelings, and report changes to the team.

Section 6: Trauma and PTSD

The past intruding on the present — very common in the people you serve.

- **What trauma is.** A response to overwhelming events. Its effects can last long after the event is over.
- **PTSD signs.** Flashbacks, nightmares, being easily startled, avoidance, and feeling constantly on guard.
- **Triggers.** Sights, sounds, or situations can set off intense reactions. What looks like overreacting is often a trauma response.
- **Trauma-informed.** Offer safety, predictability, and choice. You'll go deeper in the trauma-informed care training.

Section 7: Recognizing a client slipping

Six early signs that someone's symptoms are worsening.

- **Sleep changes.** Sleeping far more or far less than usual, or a flipped day-night pattern.
- **Withdrawal.** Pulling away from people, activities, and goals they were engaged in before.
- **Self-care drops.** Hygiene, eating, medication, and appointments start slipping.
- **Thinking shifts.** More confusion, suspicion, or trouble following a conversation.
- **Mood swings.** Sudden agitation, tearfulness, or unusual elevation and speed.
- **Risky signs.** Any talk of self-harm, harming others, or losing hope — report immediately.

Section 8: Supporting a client in distress

Three things that help in almost any hard moment.

- **Be steady.** Lower your voice, slow down, and stay calm. Your regulation helps the client find theirs.
- **Acknowledge.** Name the feeling and listen without arguing or fixing. Being heard lowers distress.
- **Loop in the team.** Report what you saw to your supervisor and the treatment team, and document it factually.

You don't have to solve the illness in the moment — steady presence and a good report are enough.

Section 9: When to get help now

Some moments are a team response, not a solo one.

- **Safety first.** Any threat to harm self or others, or a client in danger — call 911 for immediate danger, then your supervisor.
- **Crisis resources.** For a mental health crisis, the 988 Suicide and Crisis Lifeline and county mobile crisis teams can respond.
- **Sudden changes.** A fast, new change in mental state can have a medical cause — escalate rather than wait and watch.

Section 10: Caring for the caregiver

Supporting people in distress takes a toll — plan for it.

- **Name the load.** This work is emotionally heavy. Noticing that is a strength, not a weakness.

- **Use supervision.** Bring hard situations to your supervisor and team — that's what supervision is for.
- **Watch for burnout.** Exhaustion, cynicism, and dread are signals to rest and get support, not push harder.
- **Steady helps clients.** A regulated, supported worker helps clients far more than an exhausted one — your wellbeing is part of the job.

Apply It — Scenarios

The voices at the table
During a skills session, a client stops, looks frightened, and says the voices are telling him you can't be trusted. He's not aggressive, just scared and distracted.
The right response: → Stay calm and don't argue whether the voices are real — that rarely helps and can escalate. → Acknowledge his fear: focus on how he's feeling and on keeping the moment safe. → Don't diagnose or interpret — note what he said and did, in his words, factually. → Report to your supervisor and the team, especially if this is new or worsening.

The sudden high
A client who's usually quiet is suddenly talking fast, says she's barely slept, has grand new plans, and mentions she stopped a medication. You're not sure what's going on.
The right response: → Notice the cluster: little sleep, fast speech, big plans, and a medication change — describe it factually. → Don't label it 'manic' or advise her about the medication — that's outside your role. → Report promptly — a stopped medication plus a mood shift is exactly what the team needs to know now. → Stay warm and steady, keep her safe, and connect her back to her prescriber through the team.

Key Terms

Term	What it means
Rehabilitative services	Skill-building services that help a client manage illness and reach their goals.
Treatment supervision	Oversight by a mental health professional or certified rehabilitation specialist.
Decompensation	A worsening of mental health symptoms over time.
Hallucination	Sensing something that isn't there — often hearing voices.
Delusion	A fixed belief not shared or supported by evidence.
Psychosis	A loss of contact with shared reality; can include hallucinations and delusions.
Trigger	A cue that sets off a strong trauma or symptom response.
Person-first language	Naming the person before the illness — 'a person with schizophrenia.'

Check Your Understanding

1. Under 245I.05, how many hours of training must a mental health rehabilitation worker complete before providing direct contact services?
2. Mental illnesses are best understood as:
3. Which is a common sign of PTSD?
4. Which belongs in your progress note?

5. Which three actions help a client in distress?
6. A client threatens to harm himself and is in immediate danger. Your first call is:
7. Why does staff self-care matter in this work?

Looking ahead
Next, MHW-02: Recovery, Resiliency & Rehabilitative Skills — turning recognition into skill-building that lasts.

References

Minn. Stat. 245I.05 (training required); Minn. Stat. 245I.04 (provider qualifications & scope); 988 Suicide and Crisis Lifeline; county mobile crisis teams; DHS mental health guidance.

Content current as of July 2026.