



Psicossocial na Prática -

Do Gerenciamento do Risco
a Ação para a Conformidade
coma **NR01**

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Norma Regulamentadora No. 1 (NR-1)

NR-1 - DISPOSIÇÕES GERAIS E GERENCIAMENTO DE RISCOS OCUPACIONAIS

(vigência até 25 de maio de 2025)

(Última modificação: Portaria MTE nº 344, de 25 de março de 2024.)

NR-1 - DISPOSIÇÕES GERAIS E GERENCIAMENTO DE RISCOS OCUPACIONAIS

(entra em vigência 26 de maio de 2025)

(Redação dada pela Portaria MTE nº 1.419, de 27 de agosto de 2024)

AUDITORIA FISCAL DO TRABALHO

Inclusão de fatores de risco psicossociais no GRO começa em caráter educativo a partir de maio

Nova diretriz da NR-1 será acompanhada por comissão tripartite e prevê período de adaptação até 2026, com foco na promoção da saúde mental no ambiente de trabalho

Publicado em 24/04/2025 18h00 | Atualizado em 24/04/2025 18h13

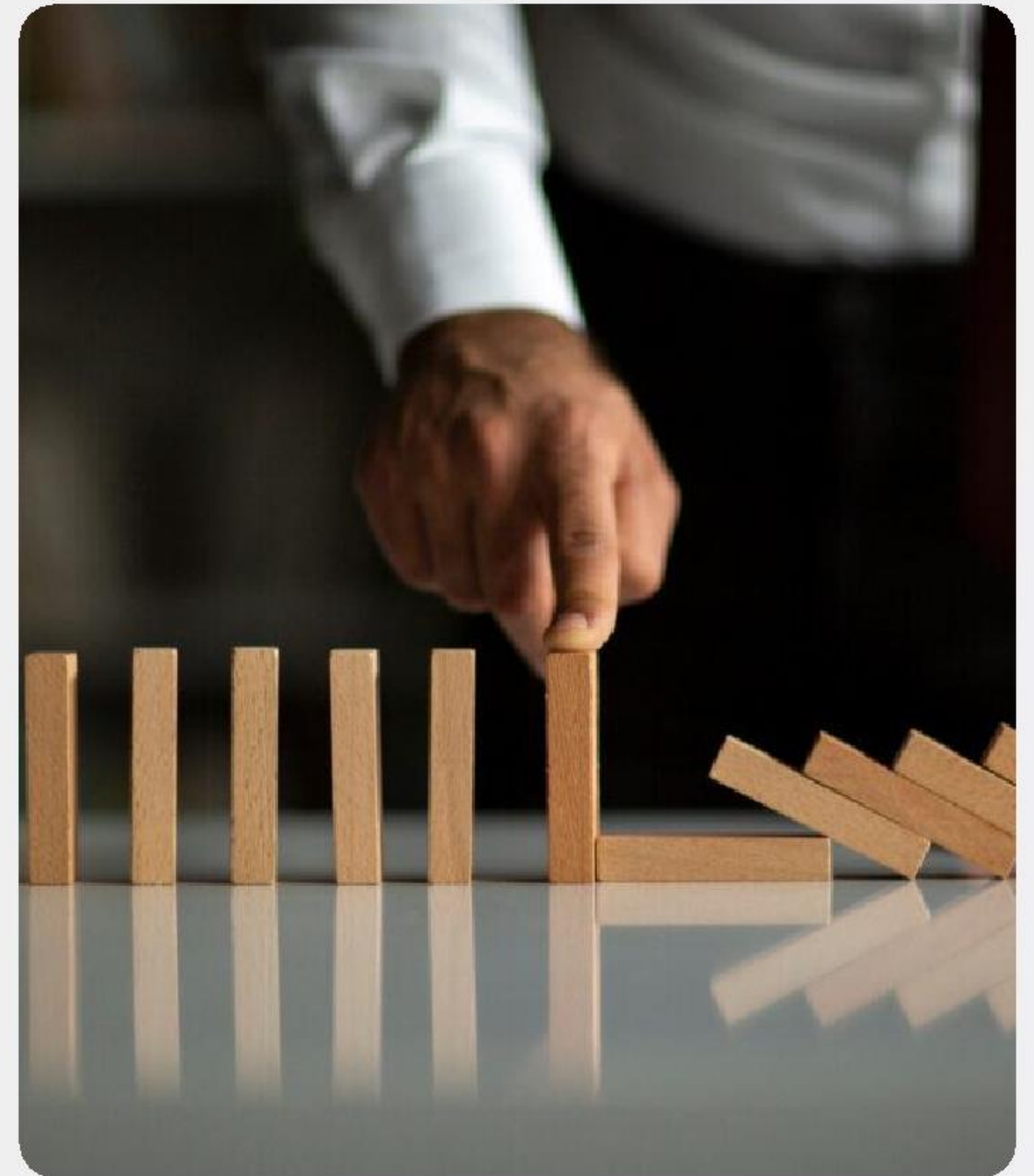
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Nova redação para o Capítulo | 1.5 - Gerenciamento de Riscos Ocupacionais

1.5.3.1.4

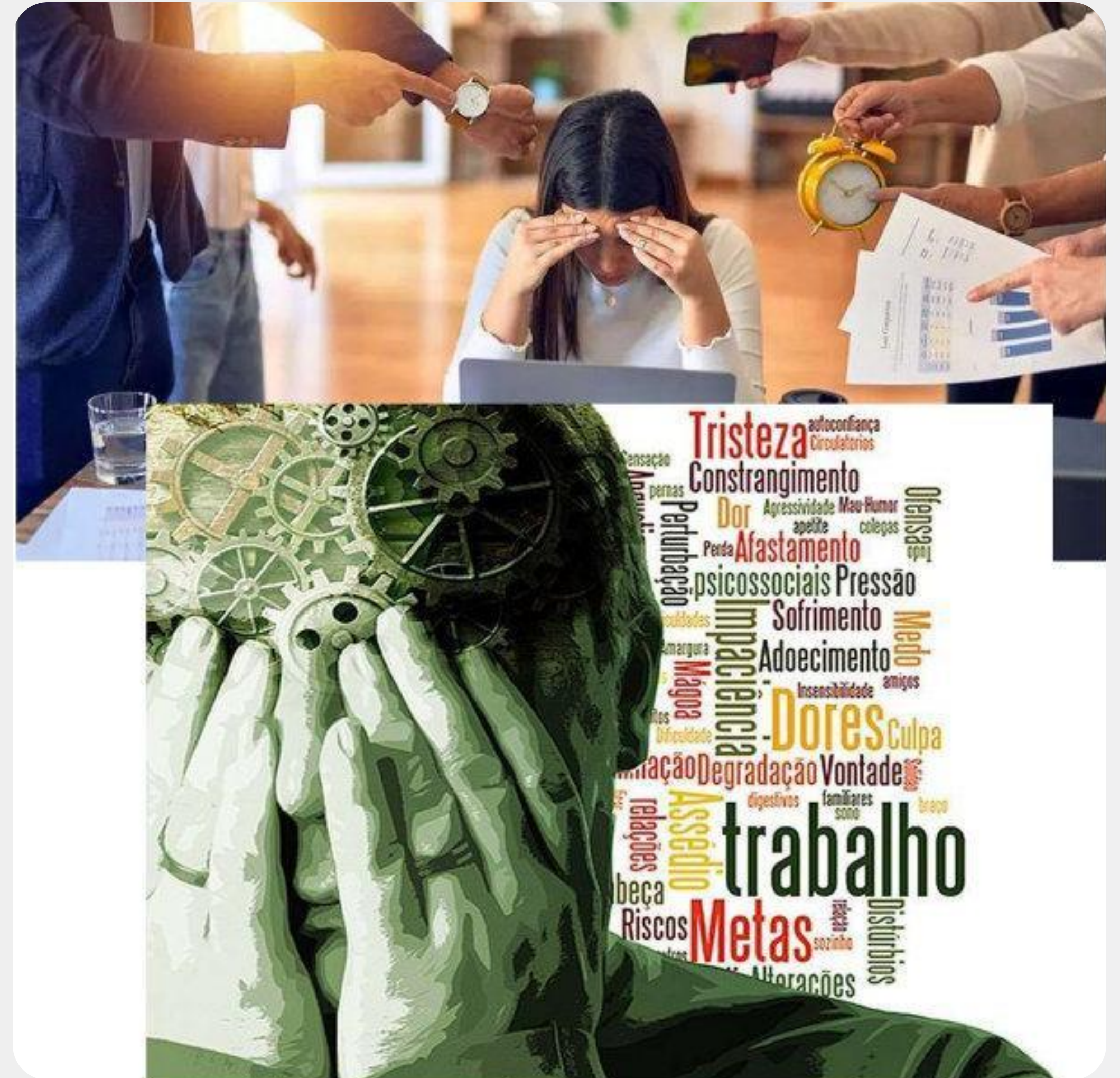
O gerenciamento de riscos ocupacionais deve abranger os riscos que decorrem dos agentes físicos, químicos, biológicos, riscos de acidentes e riscos relacionados aos fatores ergonômicos, **incluindo os fatores de risco psicossociais relacionados ao trabalho.**



Fatores de Riscos Psicossociais Relacionados ao Trabalho



Temos Perigos?





DIÁRIO OFICIAL DA UNIÃO

Publicado em: 29/11/2023 | Edição: 226 | Seção: 1 | Página: 99

Órgão: Ministério da Saúde/Gabinete da Ministra

PORTARIA GM/MS Nº 1.999, DE 27 DE NOVEMBRO

Altera a Portaria de Consolida
setembro de 2017 para atu
Relacionadas ao Trabalho (LDRT).



DIÁRIO OFICIAL DA UNIÃO

Publicado em: 05/11/2024 | Edição: 214 | Seção: 1 | Página: 50

Órgão: Ministério da Saúde/Gabinete da Ministra

PORTARIA GM/MS Nº 5.674, DE 1º DE NOVEMBRO DE 2024

Altera a Portaria de Consolidação GM/MS nº 5, de 28 de
setembro de 2017, e atualiza a Lista de Doenças Relacionadas
ao Trabalho (LDRT).

Quantidade de doenças, por categoria de CID-10^e

Capítulo da CID-10	Códigos da CID-10	1999	2020 versão 1	2020 versão 2	2020 versão 3 (final)
I – Algumas doenças infecciosas e parasitárias	A00 – A99	12	23	28	29
	B99 (inclui U06.9 e U07.1)	20	29	41	42
II – Neoplasias (tumores)	C00 – C97	14	39	50	50
III – Doenças do sangue e dos órgãos hematopoiéticos e alguns transtornos imunitários	D00 – D89	9	9	10	11
IV – Doenças endócrinas nutricionais e metabólicas	E00 – E90	2	6	6	6
V – Transtornos mentais e comportamentais	F00 – F99 (inclui X60 – X84 e Z73.0)	11	44	50	51
VI – Doenças do sistema nervoso	G00 – G99	10	13	17	17
VII – Doenças do olho e anexos	H00 – H59	7	9	11	11
VIII – Doenças do ouvido e da apófise mastoide	H60 – H95 (inclui T70.0, T70.1 e T70.3)	8	6	6	6
IX – Doenças do aparelho circulatório	I00 – I99	10	11	16	11
X – Doenças do aparelho respiratório	J00 – J99 (inclui CID R49)	21	25	28	28
XI – Doenças do aparelho digestivo	K00 – K93	7	15	16	16
XII – Doenças da pele e do tecido subcutâneo	L00 – L99 (T33 e T34)	16	19	22	22
XIII – Doenças do sistema osteomuscular e do tecido conjuntivo	M00 – M99	18	21	24	24
XIV – Doenças do aparelho geniturinário	N00 – N99	7	7	8	8
XIX – Intoxicações exógenas	T00 – T98	10	11	15	15
	TOTAL	182	287	348	347

Crise de saúde mental: Brasil tem maior número de afastamentos por ansiedade e depressão em 10 anos

Dados de 2024 mostram que o país registrou mais de 470 mil afastamentos do trabalho por transtornos mentais. Trata-se do maior número desde 2014.

Por **Poliana Casemiro**, **Rayane Moura**, g1

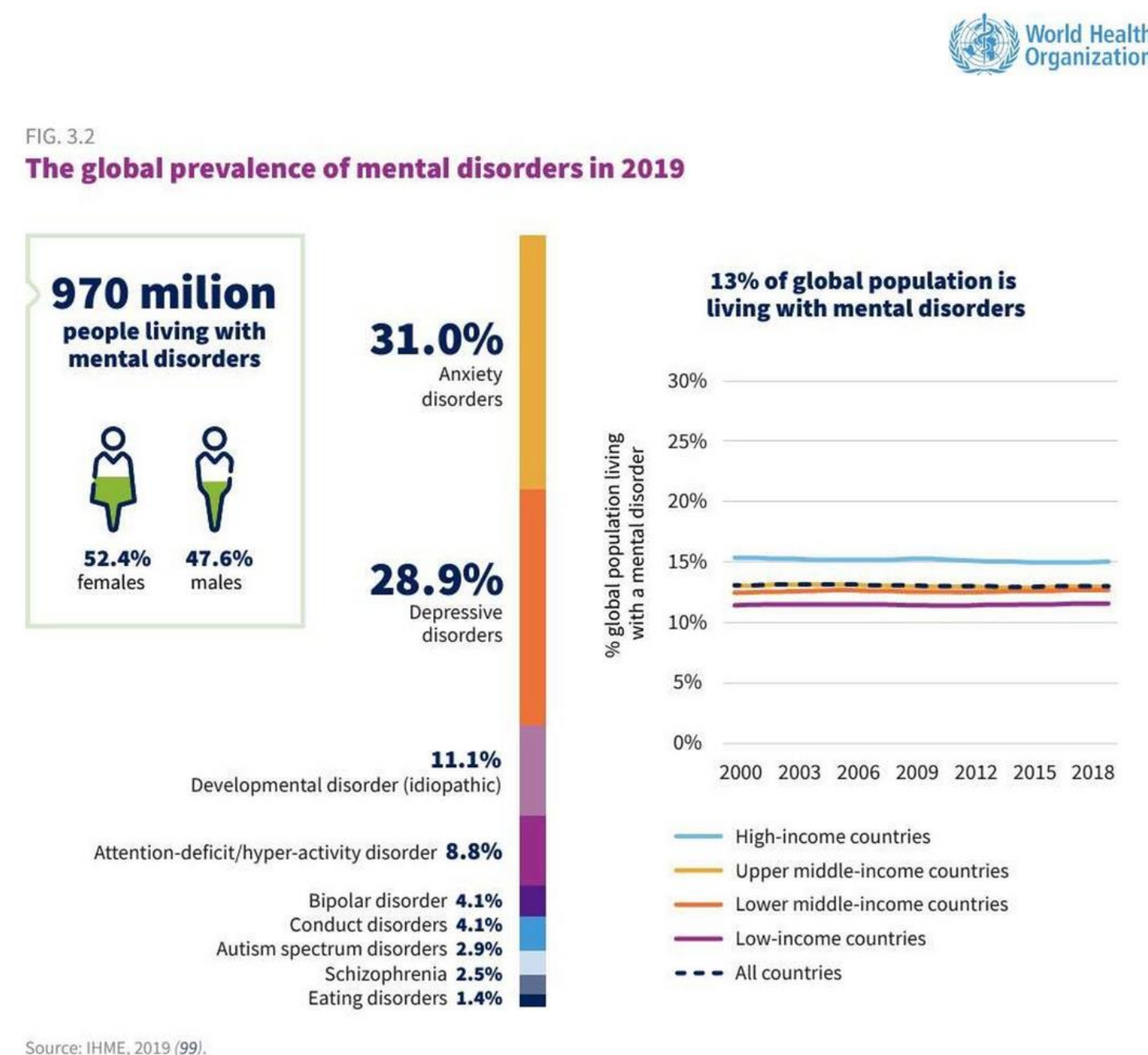
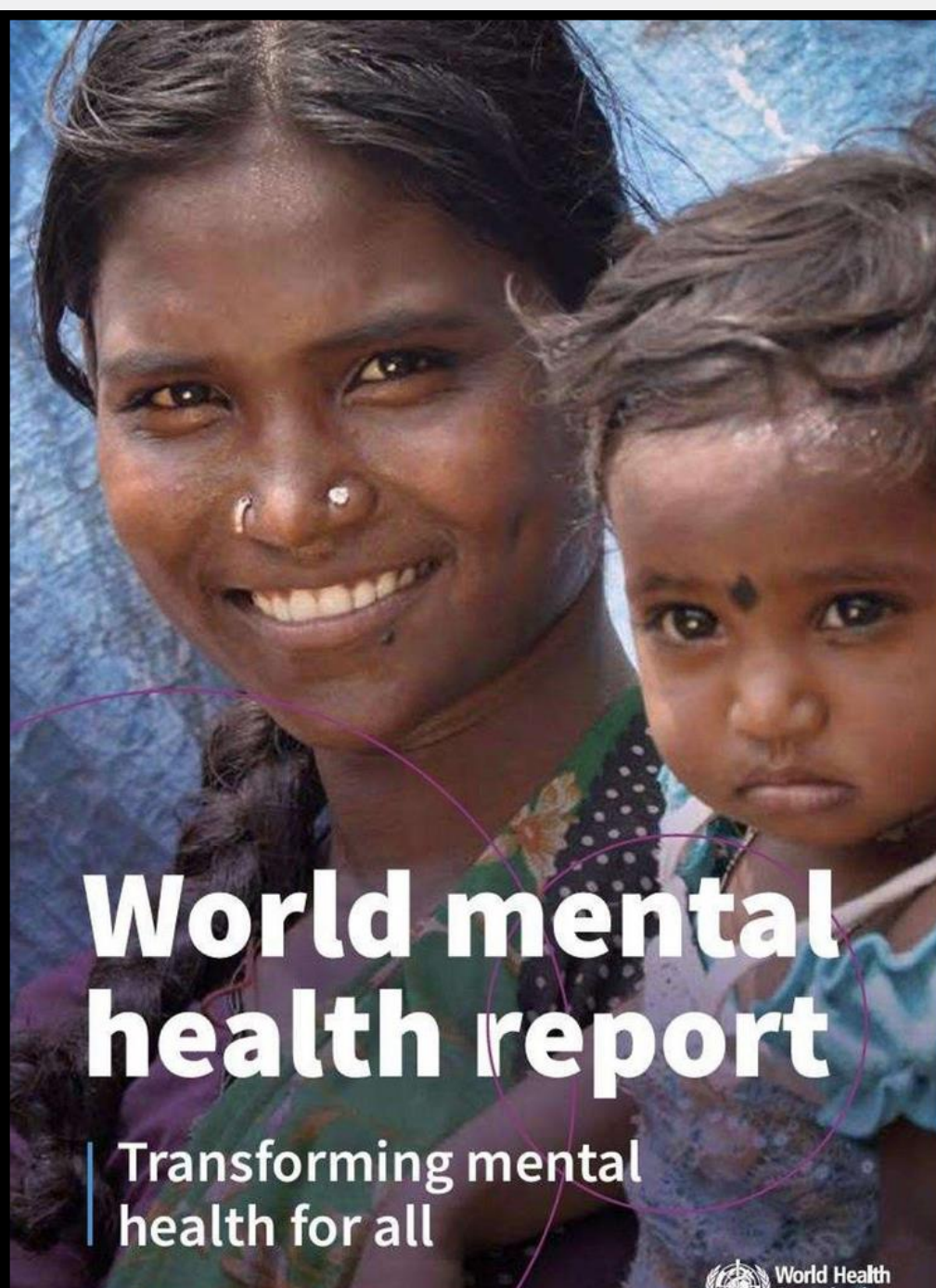
10/03/2025 00h00 · Atualizado há um mês

Afastamentos por saúde mental entre 2014 a 2024



O Brasil vive uma **crise de saúde mental** com impacto direto na vida de trabalhadores e de empresas. É o que revelam dados exclusivos do **Ministério da Previdência Social** sobre afastamentos do trabalho. Em 2024, foram **quase meio milhão de afastamentos**, o **maior número em pelo menos dez anos**.

Os dados, obtidos com exclusividade pelo **g1**, mostram que, no último ano, os transtornos mentais chegaram a uma situação incapacitante como nunca visto. Na comparação com o ano anterior, as **472.328 licenças médicas concedidas representam um aumento de 68%**. (Veja o gráfico abaixo)



Metade da população mundial vai experimental algum **transtorno mental** ao longo da vida



12 bilhões de dias de **trabalho são perdidos** anualmente em função da **depressão e ansiedade**



US\$ 6 trilhões são os **custos sociais** estimados como consequência dos **transtornos mentais**



Para cada **US\$ 1** **investido** na **prevenção e tratamento** dos transtornos mentais, **US\$ 5** são **poupados**





Association of stress-related disorders with subsequent risk of all-cause and cause-specific mortality: A population-based and sibling-controlled cohort study

Fan Tian,^{a,b} Qing Shen,^a Yihan Hu,^a Weimin Ye,^c Unnur A. Valdimarsdóttir,^{a,d,e} Huan Song,^{f,g,*} and Fang Fang^{a,f,**}

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Summary

Background Prior research provides suggestive evidence on an association between stress-related disorders and mortality. No previous study has however addressed the role of familial confounding on such association.

Methods We conducted a nationwide cohort study of 189,757 individuals with a first-onset stress-related disorder between January 1, 1981 and December 31, 2016 in Sweden (i.e., exposed patients), 1,896,352 matched unexposed individuals, and 207,479 unaffected full siblings of the exposed patients. Cox proportional hazards models were used to estimate the hazard ratios (HRs) and 95% confidence intervals (CIs) of all-cause and cause-specific mortality.

Findings During a mean follow-up of 9.42 years, an elevated risk of all-cause mortality was observed during the entire follow-up among patients with stress-related disorders, compared with either unexposed individuals or their unaffected full siblings. Such excess risk was most pronounced within the first year after diagnosis of stress-related disorders (HR, 3.19 [95% CI, 2.87-3.54] in population-based comparison; HR, 3.21 [95% CI, 2.56-4.02] in sibling-based comparison). The excess risk decreased but remained statistically significant thereafter (HR, 1.64 [95% CI, 1.60-1.67] in population-based comparison; HR, 1.61 [95% CI, 1.54-1.68] in sibling-based comparison). An increased risk was observed for almost all cause-specific mortality, with greater risk increase for deaths from unnatural causes, especially suicide, and potentially avoidable causes.

Interpretation Stress-related disorders were associated with an increased risk of all-cause mortality and multiple cause-specific mortality, and the risk elevation was independent of familial confounding. The excess mortality attributable to unnatural causes and potentially avoidable causes highlights the importance of clinical surveillance of major health hazards among patients with stress-related disorders.

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Keywords: Stress-related disorders; Post-traumatic stress disorder; Reaction to severe stress; All-cause mortality; Cause-specific mortality; Avoidable mortality

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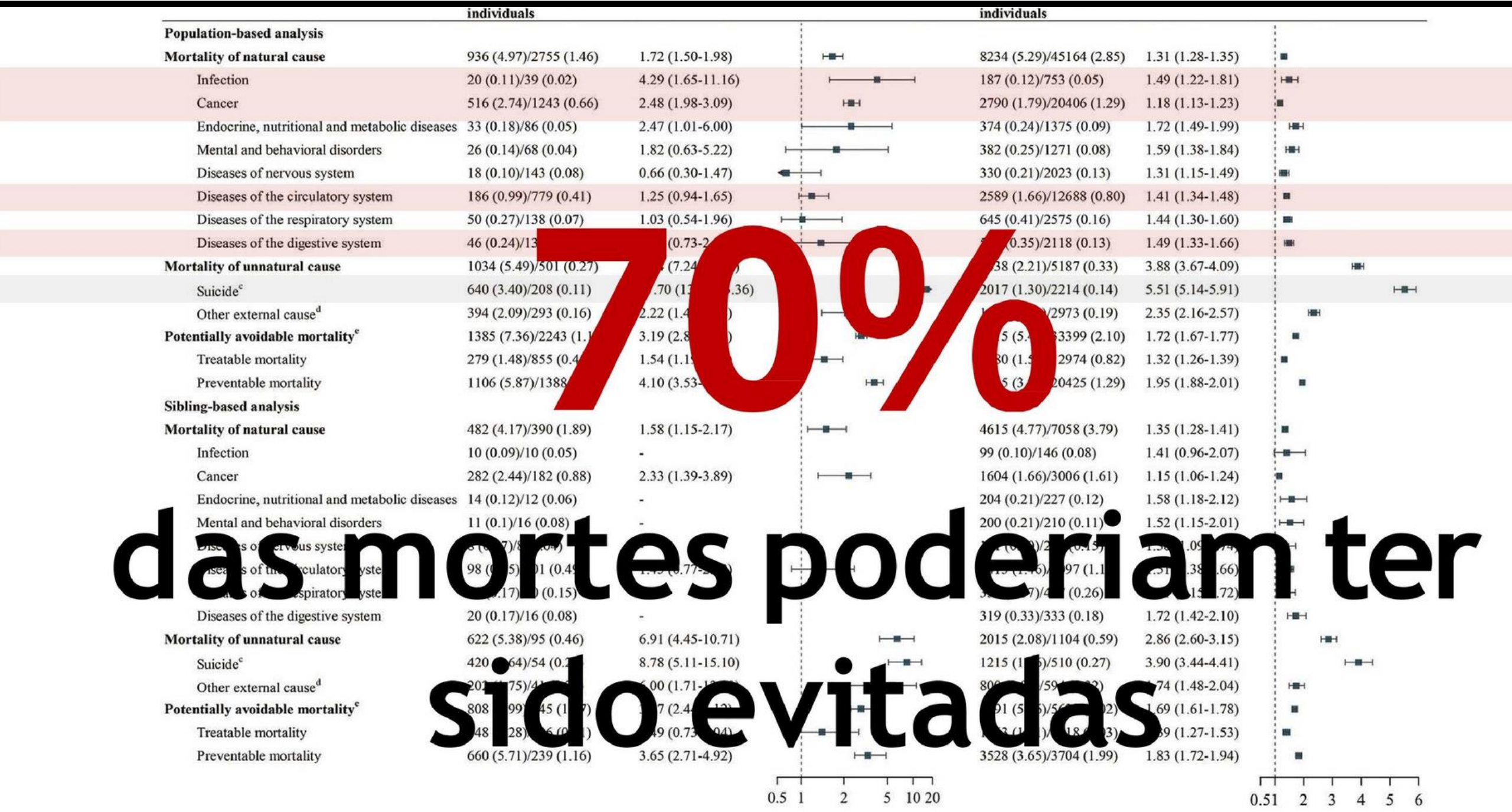
The Lancet Regional Health - Europe 2022;18: 100402
Published online 28 May 2022
<https://doi.org/10.1016/j.lanepe.2022.100402>

Characteristics	Population-based matched cohort		Sibling cohort	
	Exposed patients	Matched unexposed individuals	Exposed patients	Unaffected full siblings
No. of participants	189,757	1,896,352	116,343	207,479
Age at entry, mean (SD), years	37.33 (14.56)	37.33 (14.56)	37.55 (14.13)	38.67 (15.28)
Sex, No. (%)				
Male	71,750 (37.81)	717,136 (37.82)	44,115 (37.92)	106,138 (51.16)
Female	118,007 (62.19)	1,179,216 (62.18)	72,228 (62.08)	101,341 (48.84)
Educational level, No. (%), years				
<9	7,061 (3.72)	65,455 (3.45)	4,099 (3.52)	12,138 (5.85)
9-12	126,965 (66.91)	1,141,889 (60.22)	77,402 (66.53)	133,356 (64.27)
>12	47,691 (25.13)	625,442 (32.98)	30,800 (26.47)	52,488 (26.26)
Unknown	8,040 (4.24)	63,566 (3.35)	4,042 (3.48)	7,497 (3.62)
Marital status, No. (%)				
Single	101,139 (53.30)	998,289 (52.64)	61,609 (52.95)	99,255 (47.84)
Married or cohabiting	46,510 (24.51)	667,338 (35.19)	29,796 (25.61)	75,113 (36.20)
Divorced or widowed	35,122 (18.51)	170,749 (9.00)	21,337 (18.34)	23,249 (11.21)
Unknown	6,986 (3.68)	59,976 (3.17)	3,601 (3.10)	9,862 (4.75)
Yearly family income level, No. (%)				
Lowest 20%	62,057 (32.70)	343,459 (18.11)	29,424 (25.29)	33,554 (16.17)
Middle	98,373 (51.84)	1,118,046 (58.96)	64,105 (55.10)	124,633 (60.07)
Top 20%	22,991 (12.12)	382,371 (20.16)	19,566 (16.82)	43,337 (20.89)
Unknown	6,336 (3.34)	52,476 (2.77)	3,248 (2.79)	5,955 (2.87)
Charlson Comorbidity Index, No. (%)				
0	145,486 (76.67)	1,604,120 (84.59)	90,313 (77.63)	169,965 (81.92)
1	29,170 (15.37)	204,475 (10.78)	17,115 (14.71)	26,018 (12.54)
≥2	15,101 (7.96)	87,757 (4.63)	8,915 (7.66)	11,496 (5.54)
Type of stress-related disorders, No. (%)				
PTSD	14,521 (7.65)	-	8,376 (7.20)	-
Acute stress reaction	81,948 (43.19)	-	50,127 (43.09)	-
Adjustment disorder and other stress reactions	93,288 (49.16)	-	57,840 (49.72)	-
History of other psychiatric disorders ^a , No. (%)				
Yes	73,602 (38.79)	177,663 (9.37)	43,330 (37.24)	28,767 (13.87)
No	116,155 (61.21)	1,718,689 (90.63)	73,013 (62.76)	178,712 (86.13)
Psychiatric comorbidity ^b , No. (%)				
Yes	40,001 (21.08)	-	24,935 (21.43)	-
No	149,756 (78.92)	-	91,408 (78.57)	-
Follow-up time, mean (SD), years	9.15 (7.75)	9.45 (7.97)	9.30 (7.79)	10.04 (8.25)
Number of deaths (mortality ^c)	13,812 (7.29)	55,761 (3.11)	7,825 (7.23)	8,898 (4.27)

Table 1: Baseline characteristics and follow-up data of study participants.
^a History of other psychiatric disorders was defined as the first diagnosis of any psychiatric disorders, other than stress-related disorders, >3 months before the index date.
^b Psychiatric comorbidity was defined as the first diagnosis of any psychiatric disorders, other than stress-related disorders, from 3 months before to 1 year after diagnosis of stress-related disorders.
^c Per 1,000 person-years, unadjusted.

Model information	Population-based matched cohort		Sibling cohort	
	No. of deaths (mortality ^a) in exposed/unexposed individuals	HR (95% CI)	No. of deaths (mortality ^a) in exposed/unexposed individuals	HR (95% CI)
≤1 year of follow-up				
Model 1: adjusted for birth year, sex	2,023 (10.74)/3,305 (1.75)	6.22 (5.88-6.57)	1,123 (9.72)/492 (2.38)	4.83 (4.28-5.44)
Model 2: Model 1 + educational level, yearly family income level, marital status		4.61 (4.21-5.05)		3.84 (3.17-4.65)
Model 3: Model 2 + Charlson comorbidity index		4.15 (3.75-4.58)		3.81 (3.07-4.72)
Model 4: Model 3 + history of other psychiatric disorders		3.19 (2.87-3.54)		3.21 (2.56-4.02)
Subtypes of stress-related disorders^b				
PTSD	83 (5.74)/196 (1.36)	2.78 (1.68-4.61)	46 (5.51)/24 (1.64)	5.21 (0.34-80.36)
Acute stress reaction	1,040 (12.81)/1,539 (1.89)	3.53 (3.06-4.10)	589 (11.85)/225 (2.52)	3.52 (2.57-4.83)
Adjustment disorder and other stress reactions	900 (9.71)/1,570 (1.69)	2.90 (2.48-3.40)	488 (8.49)/243 (2.37)	2.93 (2.09-4.13)
>1 year of follow-up				
Model 1: adjusted for birth year, sex	11,789 (6.50)/835 (3.20)	2.24 (2.49-2.55)	672 (6.00)/229 (4.00)	2.07 (1.99-2.15)
Model 2: Model 1 + educational level, yearly family income level, marital status		2.20 (2.16-2.24)		1.90 (1.83-1.98)
Model 3: Model 2 + Charlson comorbidity index		1.64 (1.60-1.67)		1.82 (1.75-1.90)
Model 4: Model 3 + history of other psychiatric disorders		1.64 (1.60-1.67)		1.61 (1.54-1.68)
Subtypes of stress-related disorders^b				
PTSD	633 (6.69)/2,567 (2.68)	1.63 (1.48-1.81)	353 (6.12)/463 (4.27)	1.45 (1.21-1.75)
Acute stress reaction	5,119 (7.84)/20,952 (8.15)	1.16 (1.66-7.74)	2,917 (7.28)/3,506 (4.49)	1.64 (1.54-1.75)
Adjustment disorder and other stress reactions	5,777 (7.71)/17,417 (1.66)	1.16 (1.16-1.66)	3,640 (6.64)/4,380 (4.38)	1.52 (1.52-1.70)

Table 2: Hazard ratios (HRs) with 95% confidence intervals (CIs) for all-cause mortality among patients with stress-related disorders, compared to their matched unexposed individuals or unaffected full siblings, during or beyond the first year of follow-up.
^a Per 1,000 person-years, unadjusted.
^b HRs were derived from fully adjusted models (i.e., Model 4).

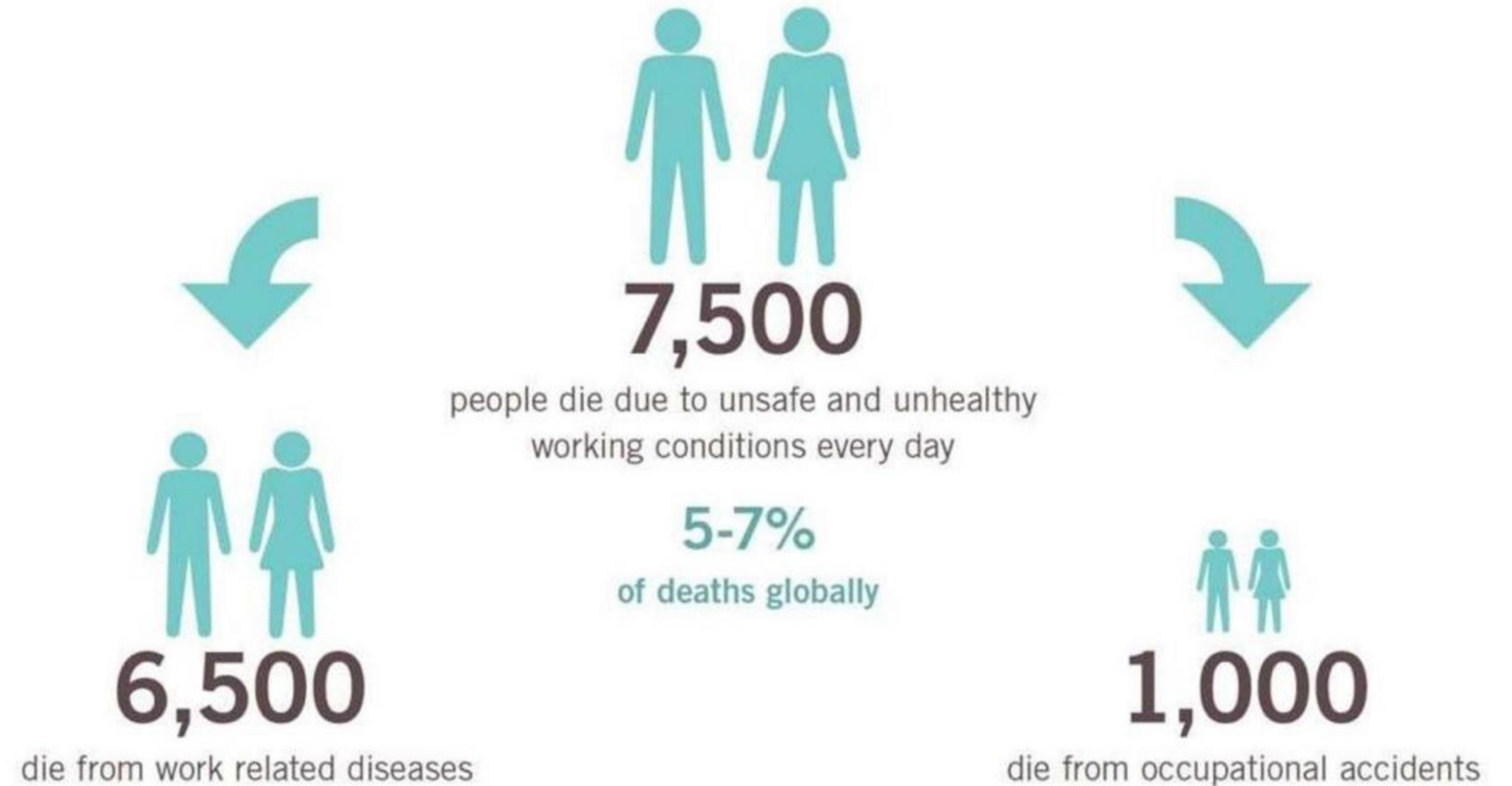


SAFETY AND HEALTH AT THE HEART OF THE FUTURE OF WORK

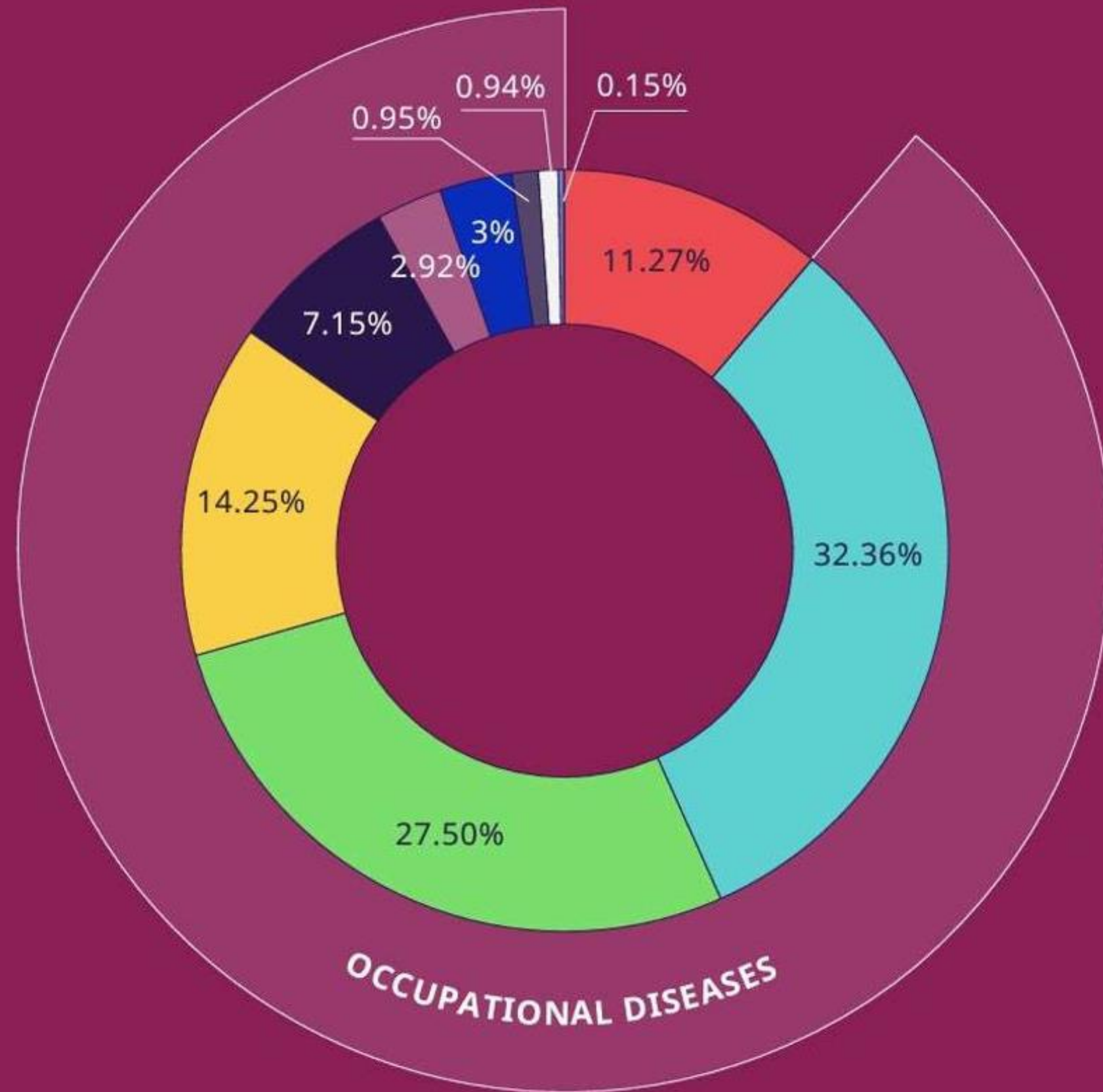
Building on 100 years
of experience



Global trends in safety and health: The picture today



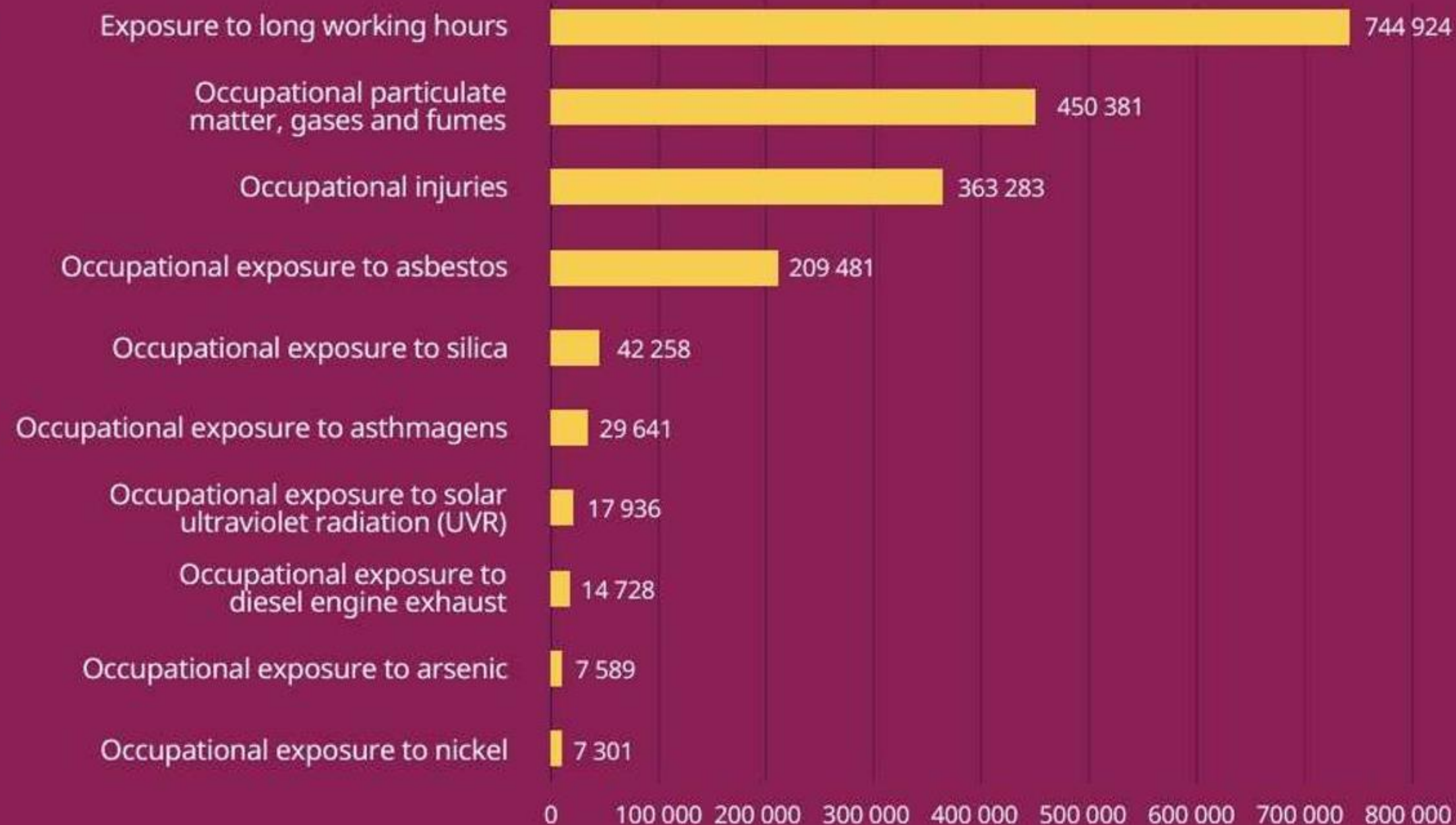
► Composition of global work-related deaths



Looking in detail at the most prevalent occupational risk factors, the World Health Organization (WHO) and the ILO developed a joint estimation methodology to produce the WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury. To date, 42 pairs of occupational risk factors and associated health outcomes (namely a specific disease or injury) have been studied. [4] [5] These estimates provide evidence on the relation between occupational exposure to specific risk factors and the subsequent negative health outcomes.

Among the 20 occupational risk factors considered, the one with the largest number of attributable deaths in 2016 was exposure to long working hours (≥ 55 hours per week), which killed almost 745,000 people, followed by exposure to occupational particulate matter, gases and fumes with over 450,000 associated deaths, and thirdly occupational injuries with over 363,000 deaths. [4] [5]

► Top 10 occupational risk factors and total number of attributable deaths



O caminho

Baseado na ciência, na literatura acadêmica e nas melhores práticas globais

Pessoas

Atitudes e
comportamentos



McKinsey
& Company

Overcoming stigma: Strategies
toward better mental health in
the workplace

Líderes

Habilidades e
Competências



Forbes

Managers Have Major Impact On
Mental Health: How To Lead For
Wellbeing

Empresas

Cultura
Organizacional



**Harvard
Business
Review**

The Future of Mental
Health at Work Is Safety,
Community, and a Healthy
Organizational Culture

O atalho

Aquelas velhas soluções milagrosas...

BRAIN MASSAGE

Experience immediate stress relief and deep rest for the mind. Surrender to the power of breath, sounds and vibration, and bring your mind into a meditative state.

BOOK NOW

READ MORE



Small Strip.
Big Benefits.



START



Desafios e Oportunidades em Saúde Mental

Não invente a roda

Qual o processo de **buscar, reconhecer e descrever** os Fatores de Risco Psicossociais Relacionados ao Trabalho?

- Gestão organizacional
- Contexto da organização do trabalho
- Características das relações sociais no trabalho
- Conteúdo das tarefas do trabalho
- Condições do ambiente de trabalho
- Interação pessoa - tarefa
- Jornada de trabalho
- Violência e Assédio moral/sexual
- Risco de morte e trauma no trabalho
- Discriminação



Qual
questionário
utilizar?

Review

An Integrated Approach to Workplace Mental Health: A Scoping Review of Instruments That Can Assist Organizations with Implementation

Adam Nebbs ^{1,*}, Angela Martin ¹, Amanda Neil ¹, Sarah Dawkins ² and Jessica Roydhouse ¹

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Abstract: This study aimed to identify instruments that may assist organizations with implementing an integrated approach to workplace mental health using three activities from the knowledge to action (KTA) framework. A scoping review of published and grey literature, supported by stakeholder (business end-user and researcher) consultation, identified work-specific instruments that were relevant to at least one of the three domains of an integrated approach to workplace mental health: 'prevent harm', 'promote the positive', and 'respond to problems'. A total of 207 instruments were located, and 109 instruments met eligibility criteria. 10 instruments were located that were relevant to multiple domains, however most instruments (n = 72) were relevant to the 'prevent harm' domain. Instruments relevant to the 'promote the positive' (n = 14) and 'respond to problems' (n = 13) domains were limited. Most instruments found were suitable for the 'monitor, review and improve' KTA activity. Further development of instruments that can assist with 'promote the positive' and 'respond to problems' strategies are required, specifically those instruments that can assist organizations with the 'identify gaps and opportunities' and 'identify priorities and design new/enhanced interventions' KTA activities.

Keywords: workplace mental health; instruments; implementation research; surveys; questionnaires

1. Introduction

Mental health concerns are common in the working population [1]. An estimated 15% of working age adults have a mental disorder at any one time [2]. It is estimated that common mental disorders, such as depression and anxiety, cost the global economy USD 1 trillion each year, primarily due to lost productivity [3]. The issue of worker mental health has, thus, been given significant attention, in recent decades, by policy makers, tripartite agencies, social partners (workers, governments and employers), and academics [4]. To address worker mental health, employers should focus on creating and maintaining a mentally healthy workplace. A mentally healthy workplace has been conceptualized as "one in which risk factors are acknowledged and appropriate action taken to minimize their potential negative impact on an individual's mental health. At the same time protective or resilience factors are fostered and maximized" [5]. One approach to creating a mentally healthy workplace is to apply "an integrated approach to workplace mental health" [6].

An integrated approach to workplace mental health is a principles-based, evidence informed framework that guides the protection and promotion of worker mental health through three overlapping domains of action (see Figure 1): 'prevent harm' (protecting mental health by reducing work-related risk factors), 'promote the positive' (promoting mental health by developing the positive aspects of work as well as worker strengths and positive capacities), and 'respond to problems' (addressing mental health problems

10G questionários

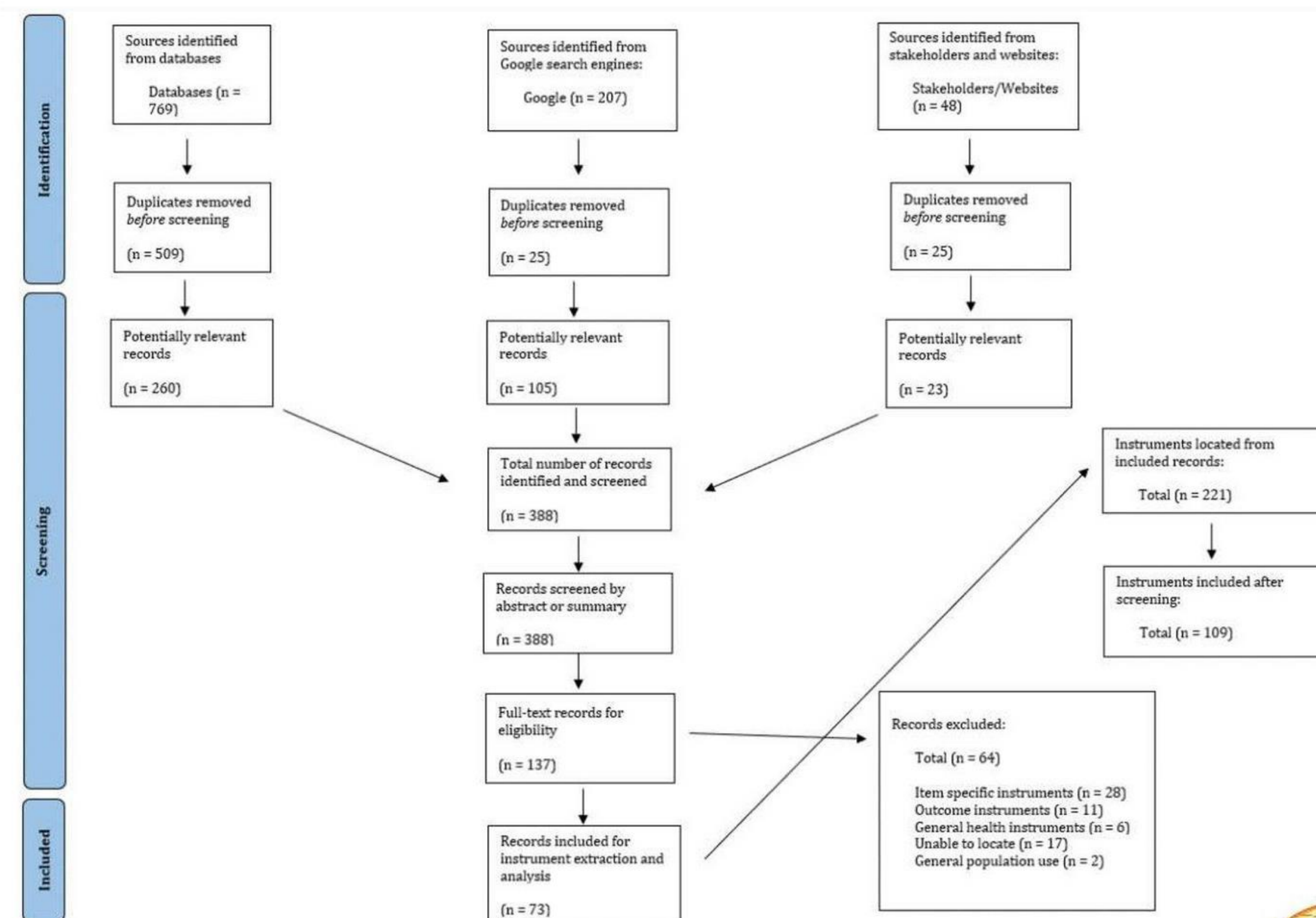


Figure 4. PRISMA flow diagram.



Citation: Nebbs, A.; Martin, A.; Neil, A.; Dawkins, S.; Roydhouse, J. An Integrated Approach to Workplace Mental Health: A Scoping Review of Instruments That Can Assist Organizations with Implementation. *Int. J. Environ. Res. Public Health* **2023**, *20*, 1192. <https://doi.org/10.3390/ijerph20021192>

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Muito além do
questionário

Quando
Começar?

AGORA!

Mental health at work:

Policy brief

KEY MESSAGES



Prevent work-related mental health conditions through psychosocial risk management which includes using organizational interventions to reshape working conditions, cultures and relationships.



Protect and promote mental health at work, especially through training and interventions that improve mental health literacy, strengthen skills to recognize and act on mental health conditions at work, and empower workers to seek support.



Support workers with mental health conditions to participate fully and equitably in work through reasonable accommodations, return-to-work programmes and supported employment initiatives.



Create an enabling environment with cross-cutting actions to improve mental health at work through leadership, investment, rights, integration, participation, evidence and compliance.

Table 1

Examples of psychosocial risks at work and organizational interventions that employers can take to address them

Aspect of work	Potential psychosocial risks	Examples of organizational interventions
Job content/task design	Lack of variety in the work; under-use of skills or under-skilled for work	- Participatory approaches to job design - Task rotation or job redesign
Workload and work pace	Heavy workloads; high work pace, high time pressures; continual and short deadlines; understaffing	- Limits on working hours or number of shifts - Achievable deadlines and targets - Adequate job demands (neither too high nor too low) - Safe staffing levels
Work schedule	Long or unsocial work hours; shift working; inflexible hours	- Participatory approaches to scheduling - Flexible working arrangements - Planned breaks - Welfare facilities and support available during atypical hours
Job control	Lack of control over job design or workload; limited participation in deciding one's own work	- Participatory approaches to job design, work organization and decision-making - Frequent and open communication
Environment and equipment	Unsafe equipment and resources; poor physical working conditions (such as poor lighting, excessive or irritating noise, poor ergonomics)	Investment in improved environments and equipment meeting health and safety legal requirements, in consultation with workers and/or their representatives
Organizational culture	Unclear organizational objectives; poor communication; culture that enables discrimination or abuse	- Opportunities for meaningful consultation and cooperation with workers and/or their representatives - Organizational frameworks for dealing with unfair treatment, offensive behaviour and abuse - Support for affected workers, including access to workers' representatives – where they exist
Interpersonal relationships at work	Social or physical isolation; limited support from supervisors or colleagues; authoritarian supervision and poor line management; violence, harassment or bullying; discrimination and exclusion	- Frameworks for preventing violence, harassment and discrimination, and for investigating and dealing effectively with incidents - Opportunities to improve knowledge, attitudes and skills for supervisors and line managers - Opportunities for peer support, including in atypical working hours or sites
Role in organization	Unclear job role within the organization or team	Clearly defined and sustainable work roles, reporting structures and performance requirements
Career development	Under- or over-promotion; job insecurity; poor investment in development; punitive procedures for sickness absence and performance management	- Fair and good career training and retraining prospects - Formal, secure work through contracts in line with national law and practice, including paid sick leave - Equal opportunities and transparency in all processes - Supportive performance management
Home-work interface	Conflicting home/work demands; being away from home for work	- Flexible working arrangements - Support for carers





World Health
Organization



International
Labour
Organization

Objetivos organizacionais pouco
claro

Falta ou pouca comunicação
Cultura que permite discriminação
ou abuso

Cultura
Organizacional

EXEMPLOS DE INTERVENÇÕES



Oportunidades para consultas dos trabalhadores

Melhoria da forma de comunicação

Cooperação com os trabalhadores e/ou seus representantes

Equipes especializadas para lidar com situações injustas de tratamento e de comportamento ofensivo ou abuso.

**Mental
health at
work:**

Policy brief





“A Medicina do Trabalho
é o que você faz dela!”

OBRIGADA

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