ISSN 2526-8910
Cad. Bras. Ter. Ocup., São Carlos, v. 26, n. 1, p. 225-240, 2018
http://dx.doi.org/10.4322/2526-8910.ctoRE1100

Experience Report

Experience of a transdisciplinary team's work along with servers in sick leave

Camila Caminha Caro[a,b], Vagner Augusto Takahashi Arakawa[b], Emanuelli Virginia Betoli de Andrade[c]

[a]Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil.
[b]Regime Próprio de Previdência Social, São José do Rio Preto, SP, Brazil.
[c]Instituto Nacional do Seguro Social, São José do Rio Preto, SP, Brazil.

Abstract: Introduction: Actions towards public servers in sick leave in a transdisciplinary perspective are necessary, however, such studies are rare in a national context. Objective: This study aimed to present an overview of the work done by a transdisciplinary team, formed by an occupational therapy, a psychotherapist, and a social worker, in evaluating, monitoring and work reinsertion of public servers during sick leave from a city in São Paulo State. Method: The work consists in reporting a transdisciplinary team's experience from a documental study of 326 servers in sick leave, attended by the team and whose absence of work occurred from March 2014 to January 2017. To this end, as experience qualifiers, the presented data was associated with the outlined profile of the attended servers and their period of absence, to the outcome of the cases after the team's interventions. Results: The number of servers away from work was reduced, especially those cases distinguished by chronic periods, after work reinsertion interventions through adequate conditions, as well as prevention of new chronic cases, by early actions from the transdisciplinary team's actions and intersectoral work. Conclusion: The article opens the discussion about the importance of a transdisciplinary work toward servers in sick leave, not only in a holistic evaluation of the functionality and incapability but also in the preparation to job reinsertion by fostering the work conditions compatible to servers functionalities.

Keywords: *Occupational Therapy, Psychology, Social Work, International Classification of Functioning, Disability and Health.*

Experiência de uma equipe transdisciplinar com servidores em afastamentos por auxílio-doença

Resumo: Introdução: Ações voltadas a servidores públicos afastados por auxílio-doença em uma perspectiva transdisciplinar se fazem necessárias, todavia são escassos os trabalhos que abordam essa temática no contexto nacional. Objetivo: Este estudo buscou apresentar um panorama geral do trabalho realizado por uma equipe transdisciplinar, composta por terapeuta ocupacional, psicólogo e assistente social, na avaliação, no acompanhamento e na reinserção laboral de servidores públicos estatutários em afastamento por auxílio-doença, de uma cidade de médio porte do interior do Estado de São Paulo. Método: Este trabalho consiste em um relato de experiência das ações desenvolvidas pela equipe transdisciplinar, a partir de um estudo documental de 326 processos de auxílio-doença de servidores atendidos pela equipe, com afastamentos entre março de 2014 e janeiro de 2017. Para tanto, foram apresentados enquanto qualificadores da experiência os dados relativos ao perfil do público atendido, aos afastamentos e aos desfechos dos casos após as intervenções da equipe transdisciplinar. Resultados: Observou-se uma redução geral do número de afastamentos na autarquia, sobretudo aqueles caracterizados por períodos crônicos, após ações de reinserção laboral por meio de condições adequadas, bem como prevenção da cronificação de novos casos por meio

Corresponding author: Camila Caminha Caro, Regime Próprio de Previdência Social do Município de São José do Rio Preto, Rua General Glicério, 3553, Centro, CEP 15015-400, São José do Rio Preto, SP, Brazil, e-mail: camilacaminhacaro@gmail.com

Received on Feb. 24, 2017; 1st Revision on May 22, 2017; Accepted on Sept. 6, 2017.

de intervenções precoces da equipe transdisciplinar e de parcerias intersetoriais. Conclusão: O artigo traz reflexões sobre a importância de um trabalho transdisciplinar voltado aos servidores em auxílio-doença, tanto na avaliação holística da funcionalidade e da incapacidade quanto na preparação para a reinserção laboral, por intermédio de condições de trabalho compatíveis com a funcionalidade dos servidores.

Palavras-chave: *Terapia Ocupacional, Psicologia, Serviço Social, Classificação Internacional de Funcionalidade, Incapacidade e Saúde.*

1 Introduction

The sick leave consists of a social security benefit with the purpose of protecting the situation of need from incapacity for work, characterized as an instrument of social protection in the work of Social Security (CUTAIT NETO, 2006). This benefit is regulated in Articles 59 to 64 of Law No. 8,213/1991, under the General Social Security System (RGPS), which aims to ensure the protection of the insured person in case of accident or incapacity to work for reasons of illness, defined as a temporary benefit paid by Social Security during disability (BRASIL, 1991).

Although economic and social implications of the national scope, especially social security, are reported in relation to this benefit (CUTAIT NETO, 2006), individual implications cannot be pointed out, with negative consequences for the subjects' health, since the work is considered one of the main social links of the worker, with important aspects related to social recognition and valorization (VASCONCELOS; OLIVEIRA, 2004), In this way, the presupposition of ruptures in this link implies to consider impacts on the health of the subjects (VASCONCELOS; OLIVEIRA, 2004), including emotional ones (LANCMAN, 2008; MENEZES, 2007), as well as difficulties with a return to work (ALEVATO, 2011; FIORIN; MESSIAS; BILBAO, 2013).

These aspects may be even more striking when considering the long periods of leaving, understanding them as being older than three months (ARNETZ et al., 2003; SHAW; PRANSKY; WINTERS, 2009). Long periods of absence are considered negative due to the impact on the psychic environment, both in leaving the work activities and to a possible return to work (SCOPEL, 2005). On the other hand, the possibility of a return to work enabled by the reinsertion policies provides the worker with fundamental feelings in this process, such as social inclusion, security, protection, utility and capacity (GRAVINA; NOGUEIRA; ROCHA, 2003).

Thus, the need for actions that make this proposal viable, especially those of an early nature is highlighted, since estimates indicate a 50% reduction in the rates of return to work after three months of absence (AMERICAN..., 2006). Also, it is fundamental to provide a return to work that prioritizes the maximum use of the server's work potential in his position of origin, maintaining the training and professional qualification, since it is a facilitating factor of this process. However, in cases where there is no such possibility, it is very important to prepare the worker for the new function, with specific actions before their qualification (TOLDRÁ et al., 2010).

In discussions between the bodies responsible for actions aimed at workers' health, such as the Ministry of Health, the Ministry of Labor and the Secretariat of Social Security, there is a strong tendency to adopt the International Classification of Functioning and Disability and Health (CIF)[1] as an important reference for actions aimed at this people (BRASIL, 2013a). This classification demystifies the tendency of the biomedical model to consider the issue of disability in a reductionist way and centered on the anatomical or physiological structures, understanding it from the psychological and social factors through the interaction between problems in the structure and/or function of the body, activities, restriction of social participation and environmental factors, which can act as facilitators or barriers to the performance of activities and to participation (ORGANIZAÇÃO..., 2003). Also, it is possible to obtain a more comprehensive view of the labor market, as well as the evaluation of the labor restrictions and potentialities for a return to work (TOLDRÁ et al., 2010).

In the current national context in which the social security reform has been widely discussed to the detriment of an eminent legal reform, the relevance of the discussions on the biopsychosocial approach of the disability benefits is highlighted, to expand the actions through the incorporation of different professionals in this process. Although medical expertise is considered an important factor in this process, and the expert is responsible for the identification of permanent or temporary work capacity or incapacity (CUTAIT NETO, 2006), the literature considers that strictly medical evaluations and

actions are ineffective in the process of reintegration into the workplace (BRASIL, 2013a). Therefore, the multidisciplinary work with leaving workers is highlighted, under the perspective of different technical-scientific knowledge, with a contribution to the specificity of action (BRASIL, 2013a).

In this context, the biopsychosocial integration of professionals into the intervention with individuals is fundamental, since it is understood that interventions must go beyond the individual and clinical scope, requiring a high complexity of knowledge of each professional that is called to perform his function in a collective work process, whose product must be the fruit of a work formed by the contribution of the different professional areas (FERREIRA; VARGA; SILVA, 2009).

Thus, the literature considers that multi-professional work consists of a collective work of reciprocal relationship between professionals, and depending on the level of integration between them, classification modalities are established. Multi-disciplinarity refers to the grouping of professionals who perform only isolated actions. The multidisciplinarity is the juxtaposition of several subjects from the cooperation among them, and there is no coordination between both. On the other hand, in inter-disciplinarity there is a hierarchy between the subjects, whose coordination and decision-making compete with a specific category of professionals, promoting the verticalization of decisions. However, trans-disciplinarity refers to the coordination of all subjects, in which all professionals are reciprocally located in their area of origin and in the area of other colleagues, because the interventions must be carried out based on a new understanding built together, without spaces to the centrality of decision-making power (FERREIRA; VARGA; SILVA, 2009). Therefore, there is neither the dilution of knowledge nor the prevalence of knowledge about the other, but rather the contribution of each specific area to multiple and common goals and objectives (IRRIBARY, 2003; TAVARES et al., 2012).

Trans-disciplinarity is a perspective of professional action to be built daily, characterized as a permanent challenge for professionals who propose to act in this way, from a movement of recognition of different positions of each in relation to the same object of intervention (FERREIRA; VARGA; SILVA, 2009). This perspective of work has been adopted in the report of experience under analysis, understanding the differentiation discussed above.

2 Actions for the Workers During Sick Leave

Historically, within the scope of the RGPS, rehabilitation actions have been implemented since 1944 through an assistance model for workers in the context of the Vocational Rehabilitation Centers (CRP), a policy that has gradually transformed as modified (TAKAHASHI; CANESQUI, 2003; INSTITUTO..., 2016). Later, with the institution of Social Security from the Federal Constitution of 1988, there was a restructuring in the definition of each public policy. In this way, the health of the worker became the competence of health policy, in partnership with other sectoral policies, as established by the Federal Constitution (INSTITUTO..., 2016; BRASIL, 1988). All these changes led to the restructuring of the professional rehabilitation process, with the closing of the CRPs and the creation of the "Reabilita" Project, which is responsible for the implementation of the professional rehabilitation process (MAENO; VILELA, 2010), being the operationalization of the Professional Rehabilitation Program (PRP) in partnership with other intersectoral policies in charge of the National Institute of Social Security (INSS) (INSTITUTO..., 2016).

Currently, within the scope of the RGPS, these actions are carried out by appointment in medical expertise, being performed by multidisciplinary teams, usually composed of professionals from different areas, such as social insurance analysts with training in social work, occupational therapy, psychology, pedagogy, among other specific training areas, acting in the habilitation and professional rehabilitation (BRASIL, 1991). These actions aim at the rehabilitation of retired workers through PRP (ROSSI et al., 2007).

This policy is part of the recommendations of the United Nations (UN), the World Health Organization (WHO) and the International Labor Organization (ILO) in which Brazil has been a signatory (ROSSI et al., 2007). They are actions established by Decree 3,048/1999, including the evaluation of the work potential, orientation, and follow-up of professional programming, articulation with the community aiming at re-entry into the labor market, follow-up and research in the labor market (BRASIL, 1999). These actions are based on principles and assumptions that comprise the worker integrated into their physical, social and family environments, guaranteeing and making feasible the basic rights (INSTITUTO..., 2016). It can be said that professional rehabilitation was inserted

as a public response to the problem of incapacity, reducing and overcoming the disadvantages produced by disabilities (MOOM; GEICKER, 1998).

In the scope of the statutory public servant[2], there is a legal provision for readaptation, which is a form of filling a position, provided in Law 8,121/1990 (article 24) within the scope of the federal public administration (BRASIL, 1990). Such normative instrument recommends the investiture of the server in charge of attributions and responsibilities compatible with the limitation that has suffered in his physical or mental capacity verified in medical expertise. In this context, there are no established legal definitions for the actions to be carried out between the different federative entities, each of them having to establish its own rules.

On the experiences in these fields, in the context of RGPS, studies point out experiences of multi and interdisciplinary teams in the context of professional rehabilitation (TAKAHASHI et al., 2010; BREGALDA; LOPES, 2011). In the public service scenario, a study was carried out that reports the experience of a multi-professional team in the context of a federal university, with actions aimed at the reinsertion of workers with partially preserved work capacity, by returning the same occupation with restrictions of activities (SAMPAIO et al., 2005). In the sphere of the municipal public service, only a manual of practices of the rehabilitation process was found, with reference to a multidisciplinary work directed to the evaluation and the reintegration of the workers in the city of São Paulo (2012). Therefore, it seems that, when it comes to this theme, most of the experiences occur in the context of multidisciplinary teams.

According to Ferreira, Varga and Silva (2009), actions in the multidisciplinary field contemplate isolated interventions among professionals and, therefore, they are characterized by a level of interaction that is not efficient in the face of the demands of the intervention object that are put daily. Therefore, they emphasize the importance of more integrated actions in professionals, which justifies the need for transdisciplinary actions, in which all professionals seek a unique knowledge based on the collaboration of each professional area. However, this type of approach is scarce, especially in the public service, since Brazil is in need of studies on the process of reintegration into the labor market, and there is no consolidated data on the health of this group of workers in the country (CUNHA; BLANK; BOING, 2009). Carneiro (2006) points out that the public administration has not yet appropriated or found difficulties in responding to the server health demands with little intervention of this scope. Therefore, it is important to highlight the relevance of this study whose objective was to report on the experience of a transdisciplinary team with statutory public servants on sick leave from a medium-sized municipality in the interior of the State of São Paulo.

3 Methods

This is an experience report carried out through the characterization of the actions carried out by the transdisciplinary team of a Social Security System (RPPS)[3], which consists of a municipal authority responsible for the management of retirement benefits, pensions for death and removals for the sickness of the City Hall, Municipal Office and other municipalities of a medium-sized in the interior of the State of São Paulo, whose average population is 400 thousand to 500 thousand inhabitants.

In this municipality, the high number of sick leave due to Mental Disorders and Behavior (MBD) and musculoskeletal disorders (MD), especially with long periods of time, and the difficulties to reinsertion of these servers led to the implementation of a program evaluation and monitoring of the servers in a holistic perspective of the subjects to overcome the inefficacy of the medical model, strictly focused on disease and disability (BORSOI, 2007; VERBRUGGE; JETTE, 1994). The implemented program also advocated the reinsertion of servers away in the context of the work, through integrated actions and server preparation when possible. Thus, in March 2014, the insertion of professionals from the field of psychology, social service and occupational therapy took place through a public tender.

The aforementioned team had its activity configured in a transdisciplinary perspective, being the choice of the professionals made to the detriment of the role of each one within the perspective of acting in team, since: the social worker acts in the defense and the expansion of the rights, by specific evaluations and guidelines with policyholders (CONSELHO..., 1993); the psychologist contributes to the survey of the representations of work, of the psychic symptoms resulting from the work activity, the understanding of the life history and the professional trajectory of the individual (TAKAHASHI et al., 2010); the occupational therapist has his/her work focused on improving the ability of subjects to engage in desired, needed or expected occupations, modifying occupation or environment to better support occupational engagement (WORLD..., 2012). Thus, it can be said that these professionals contribute to the

medical-expert evaluation process with a look that goes beyond strictly anatomical-biological aspects.

These professionals did not have any specialization or professional experience in occupational health/rehabilitation; only theoretical knowledge on the subject aggregated in the context of the graduation courses mentioned. Therefore, after entering the service, the professionals started study groups and participated in specific courses on the subject, to deepen the knowledge in question. These aspects, in association with the knowledge of each professional, enabled the construction of the service in a collective perspective, a strategy that contributed significantly to the actions of the team.

The service has been in operation for about three years and, throughout this period, the transdisciplinary team has become the main link between the expert decisions and the actions developed in the context of the reinsertion of the employees in the absence, being responsible for the follow-up and progress of cases. The actions carried out by this team comprise some stages, which will be described next, according to the procedures performed.

3.1 Screening of cases to be monitored

The first stage comprises the study of the processes of sick leave to define the eligibility or not of the cases to be followed by the team. This process follows some criteria of inclusion and exclusion established by the team in detriment of studies performed, as well as identification of some references available in the literature.

As an inclusion criterion, the authors selected the International Classification of Diseases (ICD) for neoplasms (tumors) (C), MBD (F), diseases of the nervous system (G), diseases of the circulatory system (I), musculoskeletal and connective tissue diseases (M), and injuries and fractures (S). The option for such groups of comorbidities was because they were chronic diseases, most of them incapacitating for work, initially in a temporary way, with possible unfolding in situations of disability and early retirements, characterizing an increase in social security expenditures and a high social impact (SILVA et al., 2003; MOURA; CARVALHO; SILVA, 2007). These comorbidities lead to successive and progressive loss of independence and functionality, presenting great chances of determining prolonged sick leave, a fact that justifies the importance given by the team regarding the eligibility of these specific cases (FERREIRA et al., 2012).

Cases with a primary ICD related to injury and some other consequences of external causes (S and T) were excluded, as well as other impairments not previously described: some infectious and parasitic diseases (B), diseases of the blood and hematopoietic organs (D), endocrine, nutritional and metabolic diseases (E), diseases of the eye and appendages and diseases of the ear and the mastoid (H), respiratory diseases (J), diseases of the digestive tract (K), skin and subcutaneous tissue (L) diseases, genitourinary tract (N) diseases, symptoms, signs and abnormal findings from clinical and laboratory exams not elsewhere classified (R). The exclusion of these subjects is based on the understanding that these commitments are temporary and recoverable. However, in cases of extension of leave for a period of more than three months, the team opted for follow-up of the case due to possible chronification (MOURA; CARVALHO; SILVA, 2007) and the possible need for functional restrictions in case of return to work.

With priority attention, servers whose offsets were considered chronic, that is, over three months with the same ICD or correlated ICD (ARNETZ et al., 2003; SHAW; PRANSKY; WINTERS, 2009). were followed. In this context, those whose leave was motivated by the same ICD or correlated ICD, with a duration of at least two months, could have interruptions of up to three days, referring to the end of the week, but which had previous history of withdrawal due to the same ICD or correlated ICD for at least three months. These options were due to the need for early interventions as a crucial aspect in the prevention of greater disabilities, to prevent the chronification of the sick leave, especially reducing the difficulties in the reinsertion of labor, according to the American College of Occupational and Environmental Medicine (AMERICAN..., 2006).

It is worth mentioning that the sorting is not a determining factor in the follow-up of the servers, considering that this only takes place with the intervention of the team when the servers attend the scheduled appointments and/or are found during a home visit. Otherwise, subsequent actions usually do not happen, since the absence of a specific evaluation implies difficulties in identifying the demands, especially since they are rarely identified in medical examinations.

3.2 The evaluation

The next step is to evaluate the servers through institutional visits or home visits, based on the semi-structured interview and qualified listening. The semi-structured interview consists of a set

of predefined questions, but also maintains flexibility to add others, if there is interest during the interview, providing the data search where the fact actually happens, that is in its natural environment (MINAYO, 2010). The qualified listening is directly related to the intervention by the dialogue, the reception and the creation of the bond between the server and the members of the team, allowing a better understanding of what is related to the sick leave (MAYNART et al., 2014).

The transdisciplinary evaluation of retired servants presupposes a holistic approach to each case, as well as the understanding of factors related to separation from a strictly medical perspective, to consider the following components, as proposed by the CIF: (1) functions and body structures; (2) activities and participation; (3) environmental factors; and (4) personal factors (ORGANIZAÇÃO..., 2003).

In the first component, "functions and body structures", the physiological functions of organic systems, including the psychological functions and anatomical parts of the body, such as organs, limbs, and their components, are evaluated. In this context, deficiencies are understood as problems in body functions or structure, for example, a major deviation or a loss (ORGANIZAÇÃO..., 2003).

In the "activities and participation" component, the execution of one or more tasks or actions by the individual is considered, as well as the involvement in situations of daily life, contemplating the following domains: learning and application of knowledge; tasks and general requirements; communication and mobility; self-care; domestic life; interactions and interpersonal relationships; main areas of life and community, social and civic life. The limitations of activity and participation restrictions are characterized by difficulties in carrying out activities and problems in involvement in real life situations (ORGANIZAÇÃO..., 2003).

In "environmental factors", the physical, social and attitudinal environments in which people live and lead their lives are evaluated. These factors are external to individuals and classified into two levels: (1) individual, consisting of the immediate environment of the individual (home, work and school), including the physical and environmental characteristics of the environment and direct contact with other individuals; (2) which relates to formal and informal social structures, services and rules of behavior or systems in the community or culture, including work-related organizations and services, community activities, government agencies, communication and transport services and informal social networks, as well as laws, regulations, formal and informal rules, attitudes and ideologies. Thus, it is considered that an environment with barriers or without facilitators can restrict the performance of the individual, while more facilitating environments can improve this performance (ORGANIZAÇÃO..., 2003).

Finally, in "personal factors", the particular history of life and lifestyle of the individual, including those characteristics that are not part of a health condition or state of health, such as gender, race, age other physical health conditions, lifestyle, habits, education received, different ways of facing problems, social background, level of education, profession, past and present experience, general behavior pattern, personality, individual psychological characteristics and other characteristics that may play a role in disability (ORGANIZAÇÃO..., 2003).

3.3 Intersectoral work

Meetings were held with the teams of the Specialized Service in Safety Engineering and Occupational Medicine (SEESMT), the Human Resources of Administration and the Secretaries of the City Hall Municipal (PM) and other municipalities to identify cases requiring interventions and joint evaluations with other bodies, discussing of the cases. In this context, an intersectoral work was established, whose relevance is due to the integration and articulation of knowledge, overcoming the fragmentation of knowledge and interventions. This methodology has been used in several contexts, including the public service, showing a substantial tool to increase the effectiveness of actions (PEREIRA; TEIXEIRA, 2013). In this work, worker health is understood as a collective health field, requiring integrated and articulated actions, breaking with isolated practices that do not facilitate the recovery and reinsertion of the worker (MENDES et al., 2015).

Thus, aspects of the CIF that are not included in the evaluation are discussed in an intersectional way, especially those related to "activities and participation" and "environmental factors" related to the exercise of work, for example, activities carried out in the job position, accessibility and job facilities, relationships established in the workplace, as well as possible medical and emotional factors. From this perspective, it is possible to obtain expanded data on the problematic, providing the

team with fundamental elements for the decision making regarding the direction of the cases followed.

Another aspect is the possibility of reintegration into the labor market, which is discussed with the other actors involved in the process, elucidating the factors that facilitate and constrain the process according to each perception, as well as the need for specific conditions. After identifying them, based on its specific competencies, each body assumes the commitments listed to ensure the return to work of the servers in an appropriate manner and with compatibility with their working conditions. The RPPS is in charge of evaluating and indicating the necessary conditions for a return to work, preparing the server for this process, monitoring all articulatory actions with the various partner agencies to effect the return to work; HR is responsible for the stocking/relocation of the servers before returning to work, participating in the process of choosing the location and articulating the position and activities to be performed and the services available at the municipal level; the SEESMT is responsible for the evaluation and formalization of the servers' needs, preparation of the physical and relational environment, through the evaluation and ergonomic suitability and the orientation of managers and co-workers.

3.4 Discussion of the data obtained in the evaluations

After the evaluation, the cases are discussed with the members of the transdisciplinary team to elucidate the aspects observed during the interview, constructing a general picture. This step seems crucial for a broader and more complete understanding of the circumstances in which the servers are separated, since it allows each professional to expose their vision from their competence, according to the literature (QUEIROZ; ARAUJO, 2009).

In this process, the particularities of each of the subjects are considered in a holistic perspective, to distinguish positive and negative aspects in each of the components of the CIF as well as the dynamic interaction between these components, since the functionality is understood in this perspective. Thus, the possibilities of interventions are considered, since it is considered that intervention in one element can potentially modify one or several other elements (ORGANIZAÇÃO..., 2003).

Finally, after the discussions, the team outlines the actions in the case to guarantee the rights of the servers.

3.5 Elaboration of the technical opinion

After the discussion of each evaluated case, the transdisciplinary team prepares a report of the professional interview and, afterward, a specific technical opinion of each area, whose main objective is to clarify and present the decisions to be taken in each case, based on scientific knowledge (CONSELHO..., 2014). It is an exhibition and manifestation that focuses objectively on the situation to be analyzed, based on the theoretical, ethical and technical knowledge of each professional of the team, presenting a conclusive or indicative character in relation to what was requested. Thus, it is understood that the opinion formalizes the work done, directing the medical-expert evaluation, generating relevant elements for superior decisions, which, in this study, refer to the suggestion of capacity or not for work (CONSELHO..., 2014).

This opinion contains the description of the team's service and decision, and its elaboration guided by the semi-structured interview based on the four components of the CIF already mentioned. Also, it consists of a detailed description of the interview conducted, which is prepared by all participating professionals, followed by the individual opinion of each professional, with suggestions of outcomes, to subsidize medical-expert discussions. These are weighted, based on the importance of a full performance of the work with compatibility with the functional conditions and need to promote participation, as recommended by the CIF, besides to the need to prevent new health problems of the server. Thus, the categories observed in the opinions are defined based on the concepts of functionality and incapacity of the CIF (ORGANIZAÇÃO..., 2003):

(1) common discharge, when the absence of inability to return to work under current conditions is verified;

(2) discharge with functional restrictions, when the functional capacity is partially impaired, being necessary restrictions for one or more activities, in a temporary or permanent way, not to mischaracterize the position held in original filling;

(3) discharge through functional readaptation, in cases in which the functional capacity is incompatible with the activities of the position in which the server occupies. In this process, new possibilities of professional performance are defined with the server, according to his

remaining functional capacity and profile, and actions are taken, whenever necessary, aimed at the qualification of the servers;

(4) discharge with the suggestion of transfers and/or changes in jobs, in cases where there are limiting environmental factors, such as lack of accessibility, non-ergonomic furniture, and inadequate working conditions. In this context, changes are suggested according to the institutional possibilities of physical and/or organizational modifications;

(5) discharge with the suggestion of a change in the work shift, in cases where it is observed the need for specific changes with regard to working hours due to health issues;

(6) maintenance of the benefit due to temporary incapacity for work performance, with the understanding that this incapacity is temporary and can be treated and recovered;

(7) the suggestion of disability retirement due to permanent and irreversible incapacity for any work activity, after exhausting all the possibilities of previously discriminated decisions.

After completion, this opinion is printed and attached to the process of removal from the respective servers. It is worth mentioning that, because of this, the team professionals consider the ethical limits regarding professional secrecy, so as not to expose the server nor compromise him, considering the professionals' duty to maintain professional secrecy, protecting the server in all that the professionals take knowledge as a result of the professional exercise. Therefore, there is a care with regard to what will be described in the reports and in the opinion, especially because of the bond that is established with the servants, ensuring that the information is revealed within what is necessary and pertinent at the time for the expert decision (CONSELHO..., 1993, 2005; BRASIL, 2013b).

3.6 Discussion of the cases with medical experts

In the context of the autarchy, the performance of medical experts is punctual, restricted only to medical expertise, considering that they are hired in the modality of accreditation and are not part of the efficient staff. Thus, they do not participate in the routine of the municipality and do not have contact with the other sectors involved in the process. This aspect is too negative, considering the importance of the integration of professionals, including the expert physician who is responsible for the expert decision (MAENO; VILELA, 2010; BRASIL, 2013a).

Therefore, after the opinion of the team, which precedes the medical examinations, meetings are held between the team and the medical expert with the objective of discussing the cases in their entirety, pointing out aspects and observations related to the opinion of the team regarding the outcome of the case.

3.7 Formalization of reinsertion applications

After medical examinations, the decisions of the team and of the expert physician in the cases are communicated to the competent bodies, such as the Human Resources of the Administration and of the Secretariats of the PM and other municipalities, through the Communication of Results of Medical Examination (CREM).

For cases with discharge through functional restriction, change of location, furniture suitability, ergonomic evaluation, change of shift, among other verified needs, a workflow was elaborated between the teams already mentioned and the medical experts. This flow determined that the discharge was preceded by a minimum period of 15 days, to be defined in previous discussions to provide the server's needs, with a return to adequate work compatible with his functional capacity. Regarding the cases with an indication of readaptation, a minimum period of 30 days was established, depending on the needs of the case and previous discussions, to prepare the server for reinsertion at work in the new function.

In these cases, a formal communication is sent as an official letter, which is addressed to the PM's SEESMT and to the Human Resources of the municipalities, with an appropriate deadline for taking action, as agreed in an intersectoral meeting. This communication aims to inform about the discharge decision and the need for procedures to be performed, according to the suggestions proposed by the team. The formalization of these actions is a fundamental factor in the work carried out, considering that the literature points to a greater effectiveness in the reinsertion of the server (MAENO; VILELA, 2010).

3.8 Actions to return to work in peculiar conditions

After receiving the request for the conditions to the return to work, it is up to the SEESMT to implement the subsequent actions for the evaluation of the jobs and the activities performed by the employees in their reinsertion. To that end, this body has a multidisciplinary team composed of expert physicians, occupational safety technician, nurse and social workers, who are responsible for the actions evaluation and reinsertion of the servers, guided by the request of the provident with respect to the return to work with specific conditions. It is usually up to the physician to formalize the needs, which will be later provided by the rest of the SEESMT team or other bodies. Regarding non-PM servers, it is the responsibility of the HR teams in each municipality to carry out their reinsertion work.

The adequacy of jobs is due to changes in furniture, adaptations in general and the promotion of accessibility in accordance with NBR 9050 of the Brazilian Association of Technical Standards (ABNT), which aims to establish criteria and technical parameters to be observed as regards the design, construction, installation and adaptation of the urban and rural environment, and buildings to the conditions of accessibility (ASSOCIAÇÃO..., 2015). In cases where such requests are not possible, the transfer of a location post is proposed, with the consent of the servers, and it is the HR's only responsibility of the Administration and its secretariats and local authorities to resolve the relocation needs of the server to be reinserted.

The partial restriction of work activities temporarily or permanently is defined by the occupational physician by suspending certain activities for which the employees are currently incapacitated. However, due to the potential for other activities contemplated in the position, this is maintained. In such cases, SEESMT is responsible for making the workplaces and servers official, to make it clear that medical requests are being fulfilled, to prepare the work environment, the manager and colleagues on the importance of such measures.

In the case of servers that require a total restriction for the work activities in the position in which they are filled, even though they still have the capacity to perform work in other positions, readaptation is implemented primarily in the scope of social security, interests and professional training with the servers. Then, the possibilities are discussed with the respective HR. Finally, such actions are effective in the reinsertion of labor. In this process, it is also up to SEESMT to relocate the reinserted server, the changes in the workstations and the follow-up in the return process, with guidance on the teams that will receive the servers and prepare them and the server.

3.9 Discussions about outcomes

Regarding both the functional restriction and the readaptation, the SEESMT is responsible for conducting periodic medical reassessments for the continuity or non-continuity of such measures. In addition, it is also foreseen the monitoring of the subjects submitted to these processes, aiming to monitor the cases and the recidivism in departures, especially to evaluate the work of the teams and the ways to make it more effective. The participation of the transdisciplinary team in this context occurs only in the discussion of the results in the context of intersectoral meetings, whose purpose is the appropriation of the results of the work, aiming at overcoming difficulties through the implementation of changes in the flow, and the proposition of new trajectories in unsuccessful cases.

3.10 Experiment qualifiers

In the period from March 2014 to January 2017, the transdisciplinary team met a total of 326 servers, according to the previously mentioned selection criteria, which had their disease assistance processes selected for a documentary study. After the selection of the cases, the reading and analysis of the data of the records made in the processes were done, seeking the collection of information in two categories: (1) the portrait of the public served by socio-demographic data and the distance; (2) outcomes of the cases followed up until January 2017.

Subsequently, the data collected were tabulated in Microsoft Excel® 2010 worksheets for calculating the minimum, maximum, mean and standard deviation of each of the variables. The quantitative results obtained were analyzed based on the adopted theoretical reference.

4 Results and Discussion

4.1 Profile of the assisted people

The servers assisted had a mean age of 49.8 years old, with the prevalence of the subjects in the adult age group, female and working in the PM, especially the Municipal Department of Education and Health. The most frequent positions were: elementary school

teacher, administrative assistant and general services assistant (Table 1).

Regarding the sickness situation, the servers had sick leave for one or more reasons, that is, for one or more ICDs. However, ICDs of the same letter were accounted for only once. The most common diseases were MBD (ICD F) and MO (ICD M and S) (Table 2), which is shown in consonance with an epidemiological study on the prevalence of these chronic diseases in Brazil (SILVA et al., 2003). These factors contribute to an important social impact, especially when it is considered that the majority were in the age group between 20 and 59 years old (MOURA; CARVALHO; SILVA, 2007).

Approximately 40% had a chronic absence before March 2014, a factor that can be explained by the lack of actions before joining the team that envisaged a holistic assessment of the staff, as well as the currently used reference (ORGANIZAÇÃO..., 2003). Another possible justification is the absence of a work aimed at the reinsertion of the server with different professionals focused on an approach aimed at the integration of knowledge, as proposed by the transdisciplinary team (IRRIBARY, 2003).

A little more than half (51%) of those who did not have a chronic absence in the period before the admission of the team had a chronic period of separation between March 2014 and January 2017. This factor can be explained by the tendency of chronic diseases to occur in long periods of leave rather than the progressive loss of independence and functionality (FERREIRA et al., 2012). Another aspect that may justify such a number of chronic sick leaves is the need for a time to make arrangements regarding return to work, both in relation to the workplace and in the preparation

Table 1. Sociodemographic data of the servers.

Data	Mean	Standard Deviation
Age (years old) (n=326)	49.8	11.2
Categorical variables	**Groups**	**% (n)**
Age group (n=326)	18 to 59 years old	79 (257)
	From 60 years old	21 (69)
Gender	Female	76 (248)
	Male	24 (78)
Workers (n=326)	City Hall	97 (316)
	Autarchies	2 (7)
	Chamber	1 (3)
Secretaries of the City Hall (n=316)	Education	50 (158)
	Health	29 (92)
	Others	21 (66)
Profession (n=326)	Elementary school teacher	33 (109)
	Administrative agent	12 (40)
	General Service Assistant	10 (33)
	Others	45 (144)

Table 2. Data on sick leave.

Categorical variables	ICD Groups*	% (n)
ICD (n=326) (Total of 395**)	F***	38 (150)
	M****	22 (86)
	S*****	14 (54)
	I******	7 (28)
	C*******	6 (24)
	Others	13 (53)
Chronic leave before 03/2014 (n=326)	No	60 (195)
	Yes	40 (131)
Chronic leave between 03/2014 and 01/2017 (n=195)	No	49 (96)
	Yes	51 (99)

*International Classification of Diseases; **Total number of ICDs presented among the sample considering the same letter only once; ***Mental and Behavioral Disorders; ****Osteomuscular and connective tissue diseases; *****Injuries and fractures; ******Diseases of the circulatory system; *******Neoplasms (tumors).

of the servers, although the literature recognizes negative aspects of the chronification (SCOPEL, 2005), as well as lower rates of success in return to work (AMERICAN..., 2006).

4.2 Outcomes of cases followed up

Regarding the outcomes of the cases followed, the main type of measure adopted was discharge (70%), with the common discharge as the most frequent type (73%), which shows that, although in the absence, a significant part of the employees had conditions of return to work without any specific conditions (Table 3). At the same time, this data reveals that being sick does not necessarily imply incapacity for work, since work capacity is a phenomenon that goes beyond disease, functional limitation or physical or mental disability, involving other issues such as gender, orientation and sexual identity, race, professional qualification, type of activity to be developed, family and social support, individual psychological resources and material resources, all considered decisive for the success of a (re) insertion into work (INSTITUTO..., 2016). This further reinforces the importance of a specific and careful evaluation that considers not only biological aspects but also the psychosocial, labor and environmental contexts in which the employees are inserted socially, as proposed by the CIF (INSTITUTO..., 2016; ORGANIZAÇÃO..., 2003).

In the second place (49%), discharge with functional restriction was observed, which was directed to the employees who presented incompatibility of the health condition with the exercise of one or more activities performed in their positions of origin, however with partial work capacity to exercise them, as well as in cases where the exercise of certain activities could contribute to a potential worsening of the health situation (Table 3). These aspects corroborate the right to work in compatibility with the conditions of the subjects, according to the ILO (ROSSI et al., 2007), and the need to prevent further worsening of health, through actions that restrict the execution of activities with potential to hinder the server's health or incompatible with their functional conditions, as well as less work hours (TOLDRÁ et al., 2010), as observed in other experiences (SAMPAIO et al., 2005). This contributes to the prevention of readaptation, a mode that has proved to be extremely important, since the exploitation of the residual work potential of the server in his/her position of origin, while maintaining professional training and qualification, is seen as a facilitating factor in this reinsertion process (TOLDRÁ et al., 2010).

Table 3. Cases resolutions.

Categorical variables	Groups	% (n)
Case resolution (n=326)	Discharge	70 (227)
	Retirement	18 (58)
	Death	4 (12)
	Exoneration	5 (15)
	Away	2 (8)
	Judicial process	1 (6)
Categorical variables	**Groups**	**% (n)**
Types of discharge (n=227)	Common	73 (166)
	With restriction	21 (49)
	Location change	3 (7)
	Readaptation	2 (4)
	Change of time	1 (1)
Recidivism after discharge (n=227)	Absent	64 (146)
	Present	36 (81)

Although restricted in comparison to periods before the admission of the team, readaptation indications (4%) were made (Table 3), which are only indicated in extreme cases of functional incapacity for the work of origin (BRASIL, 1990), since more difficulties are reported due to the impasse of the training and professional qualification, requiring bigger demands in the reinsertion process (TOLDRÁ et al., 2010). In spite of the difficulties, they corroborate the proposals of the CIF on the promotion of functionality based on factors of social participation and performance of activities through changes in these and/or environmental factors (ORGANIZAÇÃO..., 2003), contributing to the reduction and overcoming disability disadvantages (MOOM; GEICKER, 1998).

These specific actions for the return to work were facilitators in the process of reinsertion, confirming the literature propositions about the importance of a work that enables the professional practice with compatibility with the clinical-functional reference of the servers (TOLDRÁ et al., 2010). Although chronicity is considered a negative factor in the process of return to work (SCOPEL, 2005; AMERICAN..., 2006), the team follow-up seemed to be a possible positive factor in the return process, since, 37 of the servers with chronic leave (n=81) did not present recurrences until the present moment (Figure 1).

Together with these aspects, it was also observed that, 109 of a total of 146 servers without previous chronic periods did not present recurrences (Figure 1), which can be justified by the implementation of a holistic evaluative work, with early reinsertion with compatibility with the functionality presented by the subjects, a factor understood as a facilitator

in the process of returning to work, to prevent prolonged license and chronification of the picture (AMERICAN..., 2006; TOLDRÁ et al., 2010). The absence of recurrences can also be explained based on the positive consequences of the reintegration into the life of the subjects when this is feasible and happens with compatibility with the conditions of the subjects (GRAVINA; NOGUEIRA; ROCHA, 2003).

These data corroborate the general reduction in the number of servers leaving the municipality with chronic periods, when compared between March 2014 and January 2017, mainly due to the change in the profile of servers in chronic sick leave from MBD problems for those related to ICD C, which refers to malignant neoplasm motifs (Table 4). These data are related to the profile of chronic diseases that lead to death, since general data show that cancer represents, currently, the second cause of death in the world, with a demand for long periods of treatment, being an important question of public health (INSTITUTO..., 2012), which also justifies long periods of remission, since neoplasias require a longer period for treatment, with a variable duration of 90 days, depending on the degree of disease involvement (UNIVERSIDADE..., 2010).

In spite of these aspects, there are still many cases that present recurrences in the sample (36%)

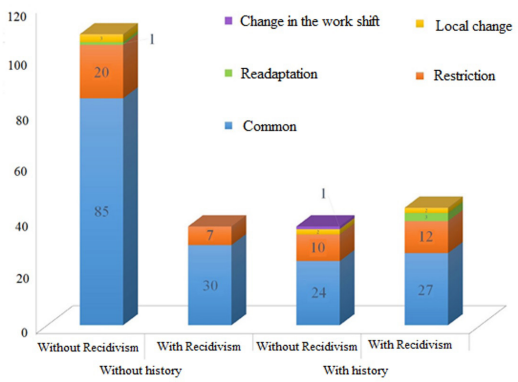

Figure 1. Data on types of discharge, recidivism, and history of removal before March 2014.

(Table 3), especially those with previous histories, as well as many who presented chronic periods before joining the team and who still have recurrences (n=44) (Figure 1). Although several cases were accompanied by the team and also were targets of actions aimed at the adequate return to work, several factors were considered as limiting in the process. These factors include aspects related to disability, such as chronicity and aggravation of the disease (MOURA; CARVALHO; SILVA, 2007), as well as personal aspects such as lack or bias in adherence to the labor return process, which also can justify such questions (GRAVINA; NOGUEIRA; ROCHA, 2003).

Another aspect possibly related to this is the absence of interventions before March 2014, aimed at reinsertion and the high number of subjects with sick leaves, above all, with a history of chronicity before joining the team (Table 2). Thus, it is considered that the monitoring by the team can contribute to decreasing the time of leaving and in higher success rates in the return process, as predicted in the literature (AMERICAN..., 2006; SCOPEL, 2005; ALEVATO, 2011; FIORIN; MESSIAS; BILBAO, 2013; BRASIL, 2013a). In addition, intersectoral work is considered, with efficient articulation between the different actors involved in the process, as an essential facilitator in the reinsertion of these subjects (TOLDRÁ et al., 2010; PEREIRA; TEIXEIRA, 2013).

It is also possible to cite the lack of standardization of the work of the team as a whole, with little support for the actions implemented, and lack of resources as a possible justification for some cases of recidivism and/or non-success in the reinsertion process. Thus, the actions in this process were restricted to PMs and municipalities, that is, the server was trained for the new function only on its return, without specific actions before his qualification, which can be a big problem, since the absence of training for the new tasks, activities and functions, as a factor that favors the subject to stay on the margins of the productive process, reinforcing experiences of failure, as well as worsening of the symptomatology

Table 4. Data referring to the number of servers in remoteness in each period.

Period (month/year)	General total of servers in sick leave*	Total number of cases followed**	Prevalent chronic ICD
03/2014	135	61	F***
03/2014-12/2016	815	99	F***
01/2017	64	12	C****

*Sick leaves for different reasons, being also considered servers with other ICDs not monitored by the team; **Servers monitored by the team with chronicity profile addressed by this study; ***Mental and Behavioral Disorders; ****Neoplasms (tumors).

(TOLDRÁ et al., 2010), implying the possible recurrences and chronicity of cases.

These aspects confirm the data of the MTE (BRASIL, 2013a), which point out that, at the national level, professional rehabilitation does not have any priority (MAENO; VILELA, 2010; BRASIL, 2013a). Furthermore, when staffing is insufficient to deal with the demands of professional rehabilitation, the organization of the process tends to generate insurmountable obstacles: the prevalence of medical decisions, without the participation of a multidisciplinary team; medical behavior and technical unpreparedness for expert evaluation; delay in evaluation and referral to the professional rehabilitation program; the lack of joint actions with all the involved organs, etc. (BRASIL, 2013a).

Therefore, it is necessary to reinforce the need to normalize work as the whole, as well as to implement an effective professional rehabilitation program, especially to ensure a return to work under compatible conditions, preventing negative consequences for both the employer and workers. That is why it is agreed that there should be, a routine practice in the continuous evaluation of actions in this scope directed to the worker by the public power (BRASIL, 2013a).

Complementing these findings, the data from this study show that the worker health area has not yet been fully embraced by public health, living a permanent challenge for its technical-operational development of health practices in general, which in many situations are isolated, disregarding sectoral policies. This aspect is one of the main challenges in the consideration of the centrality of the "work" category in the social determinants of the aggravations of the population (MENDES et al., 2015).

5 Conclusion

In general, it is possible to conclude that the actions carried out by the transdisciplinary team have been relevant in the process of evaluation, follow-up, and reinsertion of the retired employees by sick leave, especially in cases of chronic sick leaves, with substantial reduction of leaves, especially those characterized by chronicity. This experience was innovative in the area since no studies and reports of experiences in the literature on the process of reinsertion within the RPPS were found, nor was there a transdisciplinary configuration.

It can be said that the work allowed the reinsertion of workers with commitments of different orders from an expanded perspective of functionality, which considers activities, participation and the environment besides the structures and functions of the body as provided by CIF. This condition corroborates the recommendations of the UN, WHO, ILO and national laws guaranteeing the right to decent work and the health of workers.

It is highlighted the importance of work that includes non-medical professionals from a transdisciplinary approach, with the integration of knowledge in the process of evaluation, follow-up, and reinsertion of employees of statutory public servants. In addition, the importance of the intersectoral work with the PM and the municipalities, which has contributed to the discharges through specific conditions have materialized, enabling an effective work of reinsertion work of the server in an adequate and sustainable way.

It is noted that difficulties are still observed in the work carried out, which points to the need for standardization of the actions performed by the team, especially regarding the professional rehabilitation process, looking for more effective actions through legal and normative support. Also, new public policies that contemplate the health issue of the worker, counting, mainly, with the support and the collaboration of the employer are essential.

Due to the specificities in this study, there are limitations regarding the outcomes from the point of view of the employees and co-workers, as well as more detailed information about the monitoring by the PM and the municipalities. Therefore, the need for studies to demonstrate data on the effectiveness of the interventions carried out from the point of view of the servers is reinforced, aiming to identify positive and negative aspects of the work, mainly directions for improvement of the work.

References

ALEVATO, H. Os desafios da reinserção laboral dos afastados por transtornos mentais e comportamentais. *Revista Rede de Estudos do Trabalho*, Marília, n. 5, p. 139-162, 2011. Disponível em: <http://www.estudosdotrabalho.org>. Acesso em: 13 jan. 2017.

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE – ACOEM. *Preventing Needless Work Disability by Helping People Stay Employed*. USA, 2006. Disponível em: <https://www.acoem.org/PreventingNeedlessWorkDisability.aspx>. Acesso em: 15 jan. 2017.

ARNETZ, B. B. et al. Early workplace intervention for employees with musculoskeletal-related absenteeism: a prospective controlled intervention. *Journal of Occupational*

and Environmental Medicine, Baltimore, v. 45, n. 5, p. 499-506, 2003.

ASSOCIAÇÃO BRASILEIRA DE NORMAS TÉCNICAS – ABNT. *NBR 9050:* Acessibilidade a edificações, mobiliário, espaços e equipamentos urbanos. Rio de Janeiro, 2015. Disponível em: <http://www.abntonline.com.br/consultanacional>. Acesso em: 24 nov. 2016.

BORSOI, I. C. F. Da relação entre trabalho e saúde à relação entre trabalho e saúde mental. *Psicologia e Sociedade*, Porto Alegre, v. 19, p. 103-11, 2007. Número Especial.

BRASIL. *Constituição da República Federativa do Brasil*. Brasília: Centro Gráfico, 1988.

BRASIL. Lei nº 8.112, de 11 de dezembro de 1990. Dispõe sobre o regime jurídico dos servidores públicos civis da União, das autarquias e das fundações públicas federais. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 11 dez. 1990. Disponível em: <www.planalto.gov.br/ccivil_03/leis/L8112cons.htm>. Acesso em: 2 jan. 2017.

BRASIL. Lei nº 8.213, de 24 de julho de 1991. Dispõe sobre os Planos de Benefícios da Previdência Social e dá outras providências. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 24 jul. 1991. Disponível em: <www.planalto.gov.br/ccivil_03/leis/L8213cons.htm>. Acesso em: 9 dez. 2016.

BRASIL. Lei nº 9.717, de 27 de novembro de 1998. Dispõe sobre regras gerais para a organização e o funcionamento dos regimes próprios de previdência social dos servidores públicos da União, dos Estados, do Distrito Federal e dos Municípios, dos militares dos Estados e do Distrito Federal e dá outras providências. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 27 nov. 1998. Disponível em: <https://www.planalto.gov.br/CCivil_03/Leis/L9717.htm>. Acesso em: 24 nov. 2016.

BRASIL. Decreto nº 3.048, de 6 de maio de 1999. Aprova o Regulamento da Previdência Social, e dá outras providências. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 6 maio 1999. Disponível em: <www.ieprev.com.br/legislacao/leg_7188.html>. Acesso em: 2 jan. 2017.

BRASIL. Ministério do Trabalho e Emprego. *Proposta de diretrizes para uma política de reabilitação profissional.* Brasília: Ministério do Trabalho e Emprego, 2013a. Disponível em: <http://www.diesat.org.br/arquivos/DIRETRIZES-RP.pdf>. Acesso em: 5 jan. 2017.

BRASIL. Resolução nº 425, de 8 de julho de 2013. Estabelece o Código de Ética e Deontologia da Terapia Ocupacional. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 8 jul. 2013b. Disponível em: <http://www.crefito.com.br/repository/legislacao/resolu%C3%A7%C3%A3o%20425.pdf>. Acesso em: 12 fev. 2017.

BRASIL. Ministério do Trabalho e da Previdência Social. *Perguntas frequentes.* Brasília, 2016. Disponível em: <http://www.mtps.gov.br/perguntas-frequentes?catid=24>. Acesso em: 1 jun. 2016.

BREGALDA, M. M.; LOPES, R. E. O programa de Reabilitação Profissional do INSS: apontamentos iniciais a partir de uma experiência. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 19, n. 2, p. 249-261, 2011.

CARNEIRO, S. A. M. Saúde do trabalhador público: questão para a gestão de pessoas – a experiência na Prefeitura de São Paulo. *Revista do Serviço Público*, Brasília, v. 57, n. 1, p. 23-49, 2006.

CONSELHO FEDERAL DE PSICOLOGIA – CFP. *Código de Ética Profissional do Psicólogo*. Brasília, 2005. Disponível em: <http://site.cfp.org.br/wp-content/uploads/2012/07/codigo-de-etica-psicologia.pdf>. Acesso em: 10 fev. 2017.

CONSELHO FEDERAL DE SERVIÇO SOCIAL – CFESS. Lei nº 8.662, de 7 de junho de 1993. Dispõe sobre a profissão de Assistente Social e dá outras providências. *Diário Oficial da União*, Brasília, DF, 8 jun. 1993. Disponível em: <http://www.cfess.org.br/arquivos/CEP_CFESS-SITE.pdf>. Acesso em: 1 ago. 2016.

CONSELHO FEDERAL DE SERVIÇO SOCIAL – CFESS. *O Estudo Social em perícias, laudos e pareceres técnicos*: debates atuais no Judiciário, no Penitenciário e na Previdência Social. São Paulo: Cortez, 2014.

CUNHA, J. B.; BLANK, V. L. G.; BOING, A. F. Tendência temporal de afastamento do trabalho em servidores públicos (1995-2005). *Revista Brasileira de Epidemiologia*, São Paulo, v. 12, n. 2, p. 226-236, 2009.

CUTAIT NETO, M. *Auxílio-Doença*. São Paulo: Editora J. H. Zuno, 2006.

FERREIRA, H. P. et al. O impacto da doença crônica no cuidador. *Revista Brasileira de Clínica Médica*, São Paulo, v. 10, n. 4, p. 278-284, 2012.

FERREIRA, R. C.; VARGA, C. R. R.; SILVA, R. F. Trabalho em equipe multiprofissional: a perspectiva dos residentes médicos em saúde da família. *Revista Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, p.1421-1428, 2009. Suplemento 1. Disponível em: <http://www.scielosp.org/pdf/csc/v14s1/a15v14s1.pdf>. Acesso em: 3 jun. 2017.

FIORIN, G. S.; MESSIAS, J. C. C.; BILBAO, G. G. L. O retorno de professores ao trabalho após afastamentos por licença-saúde. *Revista Sul Americana de Psicologia*, Americana, v. 1, n. 2, p. 201-215, 2013.

GRAVINA, M. E. R.; NOGUEIRA, D. P.; ROCHA, L. E. Reabilitação Profissional em um banco: facilitadores e dificultadores no retorno ao trabalho. *Revista de Terapia Ocupacional da USP*, São Paulo, v. 14, n. 3, p. 19-26, 2003. Disponível em: <http://www.revistas.usp.br/rto/article/view/13911/15729>. Acesso em: 15 jan. 2017.

INSTITUTO NACIONAL DE CÂNCER JOSÉ DE ALENCAR GOMES DA SILVA – INCA. *Diretrizes para vigilância do câncer relacionado ao trabalho*. Rio de Janeiro, 2012. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/inca/diretrizes_vigilancia_cancer_trabalho.pdf>. Acesso em: 8 fev. 2017.

INSTITUTO NACIONAL DO SEGURO SOCIAL – INSS. *Manual Técnico de Procedimentos da área da Reabilitação Profissional*. Brasília: DIRSAT, 2016.

IRRIBARY, I. N. Aproximações sobre a Transdiciplinaridade: algumas linhas históricas, fundamentos, e princípios aplicados ao trabalho de equipe. *Psicologia, Reflexão e Crítica*, Porto Alegre, v. 16, n. 3, p. 483-490, 2003. Disponível em: <http://www.scielo.br/pdf/prc/v16n3/v16n3a07.pdf>. Acesso em: 2 jan. 2017.

LANCMAN, S. O mundo do trabalho e a psicodinâmica do trabalho. In: LANCMAN, S.; SZNELWAR, L. I. *Christophe Dejours*: da psicopatologia à psicodinâmica do trabalho. Rio de Janeiro: Fiocruz, 2008. p. 25-36.

MAENO, M.; VILELA, R. A. G. Reabilitação profissional no Brasil: elementos para a construção de uma política pública. *Revista Brasileira de Saúde Ocupacional*, São Paulo, v. 35, n. 121, p. 87-99, 2010.

MAYNART, W. H. C. et al. A escuta qualificada e o acolhimento na atenção psicossocial. *Acta Paulista de Enfermagem*, São Paulo, v. 27, n. 4, p. 300-303, 2014.

MENDES, J. M. R. et al. Saúde do Trabalhador: desafios na efetivação do direito à saúde. *Argumentum,* Vitória, v. 1, n. 2, p. 194-207, 2015. Disponível em: <http://periodicos.ufes.br/argumentum/article/view/10349/8253>. Acesso em: 17 fev. 2017.

MENEZES, A. O desemprego e suas consequências biopsicossociais. *Ciente Fico*, Salvador, v. 1, n. 7, p. 11-14, 2007. Disponível em: <http://www.frb.br/ciente/ADM/ADM.MENEZES.F1.pdf>. Acesso em: 5 jan. 2017.

MINAYO, M. C. S. *O desafio do conhecimento*: pesquisa qualitativa em saúde. São Paulo: Hucitec-Abrasco, 2010.

MOOM, W.; GEICKER, O. *Disability:* concepts and definitions. disability and work. Encyclopedia of Occupational Health and Safety. Geneva: OIT, 1998. CD-ROM.

MOURA, A. A. G.; CARVALHO, E. F.; SILVA, N. J. C. Repercussão das doenças crônicas não-transmissíveis na concessão de benefícios pela previdência social. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 12, n. 6, p. 1661-1672, 2007.

ORGANIZAÇÃO MUNDIAL DA SAÚDE – OMS. *CIF:* Classificação Internacional de Funcionalidade, Incapacidade e Saúde. São Paulo: EDUSP, 2003.

PEREIRA, K. Y.; TEIXEIRA, S. M. Redes e intersetorialidade nas políticas sociais: reflexões sobre sua concepção na política de assistência social. *Textos & Contextos*, Porto Alegre, v. 2, n. 1, p.114-127, 2013.

QUEIROZ, E.; ARAUJO, T. C. C. F. Trabalho de equipe em reabilitação: um estudo sobre a percepção individual e grupal dos profissionais de saúde. *Paidéia*, Ribeirão Preto, v. 19, n. 43, p. 177-187, 2009.

RANGEL, L. A. et al. Conquistas, Desafios e Perspectivas da Previdência Social no Brasil: Vinte anos após a promulgação da Constituição Federal de 1988. In: INSTITUTO DE PESQUISA ECONÔMICA APLICADA – IPEA. *Boletim de Políticas Sociais*: acompanhamento e análise. "Políticas Sociais: acompanhamento e análise - Vinte Anos da Constituição Federal". Brasília: IPEA, 2009. p. 41-94. Disponível em: <http://www.ipea.gov.br/agencia/images/stories/PDFs/politicas_sociais/05_capt02_7e.pdf>. Acesso em: 16 nov. 2016.

ROSSI, D. et al. Habilitação e Reabilitação Profissional: abordagem interdisciplinar, intersetorial e interinstitucional. In: SEMINÁRIO REABILITAÇÃO PROFISSIONAL PÚBLICA, UM DIREITO DO CIDADÃO, 2007, São Paulo, *Anais...* São Paulo: Fundacentro, 2007. Documento para discussão pública.

SAMPAIO, R. F. et al. Implantação de serviço de reabilitação profissional: a experiência da UFMG. *Fisioterapia e Pesquisa*, São Paulo, v. 12, n. 2, p. 28-34, 2005.

SÃO PAULO. Prefeitura. *Manual de readaptação, restrição funcional e reabilitação profissional.* São Paulo: Prefeitura Municipal, 2012. Disponível em: <www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/cgp/GEDEO/manual%20de%20reabilitacao.pdf>. Acesso em: 2 jan. 2017.

SCOPEL, M. J. *Retorno ao trabalho*: trajetória de trabalhadores metalúrgicos portadores de LER/DORT. 2005. 131 f. Dissertação (Mestrado em Psicologia Social e Institucional) – Universidade Federal do Rio Grande do Sul, Porto Alegre, 2005.

SHAW, W. S.; PRANSKY, G.; WINTERS, T. The back disability risk questionnaire for work-related, acute back pain: prediction of unresolved problems at 3-month follow-up. *Journal of Occupational and Environmental Medicine*, Baltimore, v. 51, n. 2, p. 185-194, 2009.

SILVA, J. J. B. et al. Doenças e agravos não-transmissíveis: bases epidemiológicas. In: ROUQUAYROL, M. Z.; ALMEIDA FILHO, N. (Org.). *Epidemiologia e saúde*. Rio de Janeiro: MEDSI, 2003. p. 289-311.

TAKAHASHI, M. A. B. C. et al. Programa de reabilitação profissional para trabalhadores com incapacidades por LER/DORT: relato de experiência do Cerest–Piracicaba, SP. *Revista Brasileira de Saúde Ocupacional*, São Paulo, v. 35, n. 121, p. 100-111, 2010.

TAKAHASHI, M. A. B. C.; CANESQUI, A. M. Pesquisa avaliativa em reabilitação profissional: a efetividade de um serviço em desconstrução. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, n. 5, p. 1473-1483, 2003.

TAVARES, A. A. et al. (Re)Organização do cotidiano de indivíduos com doenças crônicas a partir da estratégia de grupo. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 20, n. 1, p. 95-105, 2012.

TOLDRÁ, R. C. et al. Facilitadores e barreiras para o retorno ao trabalho: a experiência de trabalhadores atendidos em um centro de referência em saúde do trabalhador – SP, Brasil. *Revista Brasileira de Saúde Ocupacional*, São Paulo, v. 35, n. 121, p. 10-22, 2010.

UNIVERSIDADE ESTADUAL PAULISTA "JULIO DE MESQUITA FILHO" – UNESP. *Manual de Procedimentos de Perícia em Saúde.* Araraquara, 2010. Disponível em: <http://unesp.br/costsa/mostra_arq_multi.php?arquivo=7701>. Acesso em: 2 fev. 2017.

VASCONCELOS, Z. B.; OLIVEIRA, I. D. *Orientação vocacional*: alguns aspectos teóricos, técnicos e práticos. São Paulo: Vetor, 2004.

VERBRUGGE, L. M.; JETTE, A. M. The disablement process. *Social Science & Medicine*, Oxford, v. 38, n. 1, p. 1-14, 1994.

WORLD FEDERATION OF OCCUPATIONAL THERAPISTS – WFOT. *Definition of Occupational Therapy*. USA, 2012. Disponível em: <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx>. Acesso em: 23 fev. 2013.

Author's Contributions

Camila Caminha Caro and Vagner Augusto Takahashi Arakawa: Text design, organization of sources and/or analysis, writing of text, review. Emanuelli Virginia Betoli de Andrade: Text design, text wording, review. All authors approved the final version of the text.

Notes

[1] Created by WHO and with the first version available in Portuguese in 2003.

[2] A person legally invested in a position of effective provision, inserted in workspaces within the scope of public administration, whether direct or indirect, according to Federal Law No. 8,112/1990 (BRASIL, 1990).

[3] The RPPS has its origin in the constitutional context, in article 40, as a possibility of social protection of statutory effective servants, whose general rules for organization and functioning are set forth in Federal Law 9,717/1998 (BRASIL, 1988, 1998). This is a social security system established within each federal entity, with the purpose of ensuring by law, minimally, the retirement benefits and pensions for the death of these employees, and is later regulated by other legislation, such as the EC nº 41, which generated greater isonomy among social security regimes (BRASIL, 2016; RANGEL et al., 2009).