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Onward with the Anti-asylum Struggle, occupying city master plans

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Abstract *This article reflects on the limits and possibilities for articulating the anti-asylum struggle with participatory city master plans (PMPs) in Brazil with the aim of helping enhance anti -asylum care in liberty and guaranteeing the rights of people experiencing mental suffering. Departing from the premise that the city is neither a therapeutic nor a caring environment, this analysis seeks to weave together the challenges of "living in liberty" with urban planning policies guided by PMPs. To this end, we analyzed terms pertaining to the anti-asylum struggle and Brazil's mental health reform in the PMPs of the 15 highest-scoring cities in the Connected Smart Cities Ranking. The findings show that it is important for the anti -asylum struggle to dispute municipal urban policies in wider legislative arenas in order to promote further advances in deinstitutionalization and a transformation of the social place of madness, and guarantee the rights of people experiencing mental suffering in cities.*

Key words *Citizenship, Deinstitutionalization, Social participation, City planning, Mental health*

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Introduction

Significant strides have been made in the reorganization of mental health care in the 20 years since the initiation of Brazil's mental health reform by Law 10216/2001[1,2]. Dehospitalization, the creation of extrahospital services and the organization of psychosocial care networks (PSCNs) have been important victories for the advance of the anti-asylum struggle, especially when it comes to the deinstitutionalization of people experiencing mental suffering[3] and the consolidation of the psychosocial care paradigm in Brazil[4,5].

In contrast to the biomedical and hospital centric approach, the psychosocial care paradigm adopts other care strategies focused on the creation and strengthening of affiliation, affirmation of differences and health promotion[5]. The notion of differences-liberty-life therefore asserts itself in opposition to the diagnosis-medicalization-cure process.

In spatial terms, going against the historical practices of "social abduction", the deinstitutionalization approach focuses on the city, a place of multiplicity and differences, to enhance the lives of people suffering from mental illness – the city as a locus of transformation of the social place of madness. In short, this approach seeks to promote a shift in practices and meanings of mental health care, which can be summed up in the following terms: "from the asylum, place of zero social exchange, to the extreme multiplicity of social relations"[6] (p. 36).

Considering the centrality of the city to therapy and the fact that "living in liberty" is the sine qua non condition for the transduction of the subject-subjected into subject-citizen existing, inhabiting and living in the city poses challenges to people experiencing mental suffering, not only in relation to clinical practice, but also with regard to the concrete possibilities of effectively exercising citizenship[7]. While on the one hand, *the patient becomes a citizen with full rights, thus changing his/her contractuality in relation to society in general*[6] (p. 36), on the other, the realization of these rights of citizenship (social, political and human) comes up against other obstacles, which are not just legal and normative, but rather consist of a set of structural disparities, socio-spatial inequalities and geographies of exclusion and oppression, characterizing the everyday reality of Brazilian cities.

At the heart not only of social problems and the sphere of (re)production of inequalities and injustice, but also struggles for emancipation[8], city territories end up circumscribing the different and unequal possibilities open to diverse social subjects as regards access to rights and services that are essential to social and individual life. In this sense, it is important to consider the historical process of capitalist urbanization in the formation of territories in Brazilian cities, which has given rise to an unequal distribution of urban social resources[9,10]. Driven by production and consumption, capitalist spatial planning is therefore another challenge to citizenship, being at the same time the product and producer of selectivity when it comes to the capacity of certain population groups to realize their rights[11]. Characterized by inequalities and injustice, the territories utilized in cities end up becoming "spaces without citizens" – "the capacity to utilize the territory not only divides but also separates men, even though they appear to be together"[12] (p. 59). In the words of Milton Santos, the reality delineated in Brazilian cities is that of stunted and mutilated citizenship, since, "*for many, the existing urban network and corresponding service networks are only real for others. Hence they are diminished, incomplete citizens*"[12]. (p. 112).

From the point of view of geographies of existences, the territories where we live are not simply a set of objects through which we play out our daily lives, in compliance or not with the rules. The "macro" problems of models of urbanization and urban planning produced in agonistic governments, markets, corporations and civil society are added to the micropolitics of everyday social interactions, permeated by forms of intersectionalized oppression (stemming from normativity, race, gender and class). According to Jorge Luiz Barbosa[13], the socio-spatial mobility of people in the city extends far beyond accessibility to urban social resources, involving an urgent need to undo a whole set of geographies of oppression looming in the potential trajectories followed by people in these territories. Thus, the city that is sought as an ever open place of multiplicity dynamized by everyday interactions and, therefore, a powerful driver of multiple diverse experiences, is also structurally objectified as a place of social suffering.

Society is sick. This society is their city. This overdetermination calls into question the acceptation of the city, community and territory as idealized static *entities*, or as naturally "good" and "caring" "subjects", insofar as these concepts conceal the fact that, before the asylum, the institutionalized subject came precisely from a socio-spatial reality that may have made him sick.

That being the case, we align ourselves with the not-so-new defense of the transformation of the city as a prerequisite for an effective mental health policy[14,15]. From our perspective, within the scope of the anti-asylum struggle and Brazil's mental health reform, deinstitutionalization requires us to contend for the city not only in the micro-politics of the everyday, but also within the sphere of city planning and management. This is because conquering the right to the city is not defined by the simple fact of "living in liberty" – although this may be a minimum prerequisite for establishing this right. To deliver care in/with the city, this space needs to be transformed into a space that is a powerful promoter of care – which extends beyond the corporate boundaries of mental health care (even considering the broader, off-centered, multidisciplinary and trans/interdisciplinary meaning of care). Although territorialized care is essential – tensioning in loco the territorial arena in which treatment plans and people's lives are played out – there is an urgent need to intervene collectively on a larger scale in dialogue with city planning and management.

Departing from this premise, this article reflects on the limitations and possibilities for articulating the anti-asylum struggle with urban policy in municipalities in Brazil, focusing on participatory city master plans (PMPs), with the aim of helping enhance anti-asylum care in liberty, and guaranteeing and expanding the rights of people experiencing mental suffering.

By conducting a comparative analysis of the PMPs of the 15 highest-scoring municipalities in the Connected Smart Cities Ranking[16], it was possible to develop an in-depth guiding question: how have mental health issues pertaining to the anti-asylum struggle and Brazil's mental health reform been addressed in macro urban planning in cities across the country?

Analyzing city master plans: what place does mental health have?

Created by the 1988 Federal Constitution and redefined and expanded by the City Statute in 2001, the PMP is the primary legal instrument orienting urban development, growth and planning. It is mandatory for cities with a population of more than 20,000 inhabitants and/or components of metropolitan regions, urban agglomerations, areas of special interest for tourism, and areas located in the zone of influence of development initiatives with a major environmental impact. The PMP is the backbone of urban policy and the following instruments are subordinate to the plan: the multi-year plan, *budgetary guidelines* and annual budget, which must, for example, follow the *guidelines* and priorities defined in the plan[17]. In view of its importance, the PMP must be reviewed every 10 years. Governments that do not comply with this requirement are subject to the penalties set out in the City Statute.

In its current form, the PMP is a legal framework intended to express the achievements of different social movements in their struggle for urban reform and the right to the city in recent decades. The plan's guidelines are essential for defining parameters, instruments, plans and goals, articulating a broad set of other planning, control and management instruments set out in the City Statute, which should be strategically organized and tailored to local realities. PMPs thus seek to ensure the provision, direction, and legal and legislative certainty of some of the underlying principles of the democratization of cities, including: the social function of urban property, the social function of the city, and the right to the city and a balanced environment.

With regard to the public sphere, it is through the construction of the PMP that the city "joins the dispute" over the definition of strategic zoning, planning guidelines, and development of plans (including sectoral plans), establishing parameters, goals and timeframes, as well as setting guidelines on matters such as mobility, health, education, culture, and the environment. In other words, resulting from a long development and review process encompassing diagnosis and scenario forecasting, ostensibly with public participation, the PMP is the institutional framework for "designing", "thinking", and "dreaming" about the city. Once created, the plan takes the shape of law, processed by public hearings to define modifications and subsequent voting. The PMP construction process should seek to configure a broad social arena of dispute, giving precedence to public participation, promoting public debate about different projects geared towards the city (and living the city and in and with the city) on the local agenda.

Although participation is not the specific focus of this article, it is precisely considering the mandatory nature of broad public participation in the PMP formulation process that we embark on an investigation of the ways in which mental health issues – seen through the prism of the anti-asylum struggle and Brazil`s mental health reform – have been incorporated into these legal instruments.

The screening, analysis and comparison of the PMPs from different cities around the country was based on the ranking of urban quality updated annually by the Connected Smart Cities platform, which uses the following indicators: economy, education, entrepreneurship, governance, the environment, mobility, accessibility, health, security, technology and innovation, and urbanism. The CSC Ranking[16] maps the country's cities with the greatest potential for urban growth and development. Although the assessment is a corporative initiative, the method involves the ranking of different indicators of development, quality of life and sustainability, providing a comparative overview of urban conditions – the ranking also takes into account city size and regional differences.

Of the 100 cities included in the assessment, we focused on the PMPs of the 15 highest-ranked cities, filtering the search of the documents using keywords. An initial search using the term "health" revealed various mentions of the word in a diverse range of different contexts, involving different uses and meanings, and referencing a range of topics, which were classified into the following themes:

Constitutional rights: health (in legal terms); health protection; human health; environmental health; recovery of individual and collective health; health needs; health promotion; disease prevention; health and citizenship; comprehensive health care; good health conditions and safety; health and well-being; health care; women's, child and adolescent health, old person's health, and the health of people with disabilities and chronic diseases.

Health planning and management: public health; sectoral health plans; World Health Organisation standards; health research; health information; departments of health; Brazil's national health system (*Sistema Único de Saúde* - SUS); health care models; health surveillance; epidemiological surveillance; health care networks; national health policy; new health technologies; management of local health networks; interfederative management of the SUS; municipal health policy; participatory management; primary and secondary care facilities; integrated levels of health services; the Family Health Program.

Health effects of city activities and living: potential health risks and risk of death; health (in relation to sanitation and pollution); population health problems.

Service network and facilities: community health workers; health waste; occupational health; health centers; general hospitals; specialist hospitals; health posts; outpatient clinics; oral health.

It is worth highlighting two interesting details in specific PMPs. The first was in the PMP of Niterói, Rio de Janeiro (2019)[18], which was the plan that mentioned the word "health" most (61 mentions). Although most of the terms mentioned above were recurrent the plan, others warrant highlighting: comprehensive women's, child and adolescent health care; health and quality of life of the older population, people with disabilities and chronic disease; health action planning; three levels of health care; epidemiologic profile; family health; specialist health centers and laboratories; and health information and research.

The second was in the PMP of Curitiba, Paraná[19], which was the only plan to make direct reference to the terms "collective health" and "determinants of health". The same can be said for the term "community health", which was only found in the PMP of Porto Alegre, Rio Grande do Sul[20] – although the latter does not make any mention of mental health.

With regard to mentions more strictly linked to health network management, planning and organization mechanisms, Rio de Janeiro's PMP[21] is worth highlighting because it is the only plan that contained the term "metropolitan health plan".

Other important details were observed in the PMP of Barueri, São Paulo (created in 2006 and update by a complementary law in 2019), which was the only plan to mention the term "healthy city":

Chapter II, Article 9 – The process of urbanization of territory in the Municipality is organized around core integrating and structural elements. [...] §2. The integrating elements are those that make up urban function grouped by objective, as follows: [...] VI – Healthy City, which brings together preventive and curative health actions, acting also on environmental and territorial factors that influence public health[22].

But what place do *the mad* have in the city?

We performed a more detailed analysis of the documents using the terms "mental health", "psychosocial", "alcohol", "PSCS (psychosocial care center)", "PSCNs", "day center", "sanatorium", "asylum", "psychiatric hospitals", "beds" and "network". The results are synthesized in Chart1.

Only six cities directly mention the above terms in their PMP: São Paulo (PMP created in 2014, 1st in the CSC Ranking)[23]; Curitiba (PMP created in 2015, 3rd in the CSC Ranking)[19]; Vitória, Espírito Santo (PMP created in 2016, 5th in the CSC Ranking)[24]; Brasília (PMP created in

Chart 1. Synthesis of the mentions of terms linked to mental health and the anti-asylum struggle in the city master plans of the 15 highest-scoring cities in the Connected Smart Cities Ranking.

Ranking	Score	Population	Master Plan	Creation	Mentions	Term used	Text
1	37,901	500,000 +	São Paulo (SP)	1 August 2014	1 (31)	Psychosocial care center (PSCS)	CHAPTER VIII, Section I, Sole paragraph – Urban social facilities are listed in Box 10 in the appendix
2	37,224	500,000 +	Florianópolis (SC)	14 January 2014	0	-	-
3	36,545	500,000 +	Curitiba (PR)	17 December 2015	1	Drug and alcohol use	Section VI, Article 116, X - develop actions to prevent the use of drugs and alcohol, creating methods and ways of delivering specialist care, with the aim or providing effective humanized treatment under the Unified Health System – SUS
4	36,303	500,000 +	Campinas (SP)	27 December 2006	0	-	-
5	36,251	Between 100,000 and 500,000	Vitória (ES)	13 October 2016	1	Sanatorium	Chapter II, Section I, Article 152: In calculating lot occupancy, except for single-family residential properties, the following shall not be included: [...] IV – the area of verandas that are contiguous to rooms not exceeding: [...] b) 20% (twenty per cent) of the area of the respective room in hotel, motel, apart-hotel, pension, hospital, health and care home, sanatorium and maternity accommodation units
6	36,107	Between 100,000 and 500,000	São Caetano do Sul (SP)	9 December 2015	0	-	-
7	35,423	Between 100,000 and 500,000	Santos (SP)	16 July 2018	0	-	-
8	35,361	500,000 +	Brasília (DF)	25 April 2009 (updated by a complementary law on 15 October 2015)	1	Specialist mental health hospitals	Chapter VIII, Article 52, Regional facilities are establishments in which services in the thematic areas of education, public security, health, transport, supply and culture are provided. [...] III – health: regional hospitals, specialist mental health hospitals and health surveillance units; (clause from Complementary Law 854/2012). Original text: III – health: regional hospitals and health surveillance units
9	34,869	500,000 +	Porto Alegre (RS)	1 December 1999 (updated by a complementary law on 22 July 2010)	0	-	-

it continues

Chart 1. Synthesis of the mentions of terms linked to mental health and the anti-asylum struggle in the city master plans of the 15 highest-scoring cities in the Connected Smart Cities Ranking.

Ranking	Score	Population	Master Plan	Creation	Mentions	Term used	Text
10	34,608	500,000 +	Belo Horizonte (MG)	8 August 2019	0	-	-
11	34,411	500,000 +	Niterói (RJ)	3 July 2019	2	Mental health care; day centers	Chapter IV, Article 253: The guidelines set out in social development policies, which include education, health, social assistance, sport and leisure, comprise:: VII - broadening and promoting intersectoral actions geared towards strengthening mental health care, with emphasis on tackling crack and other drug addictions in the city's hospital units; E, Article 267. The Municipal System for the Protection of Cultural Heritage has the following objectives: VII - VII – to stimulate the revitalization of historic buildings located in ZEPAC-APAU [special cultural environment preservation zones - urban environment preservation areas] for activities geared towards older persons, such as medical clinics, day centers and health facilities in general
12	34,297	500,000 +	Rio de Janeiro (RJ)	1 February 2011	1	Psychosocial recovery	SECTION III – SOCIAL ASSISTANCE, SUBSECTION II, Article 267. The Social Assistance Policy will be implemented through programs defined by the Municipal Social Assistance Council, which shall consist of: the creation, refurbishment and maintenance of assistance centers for people in need; incentives for the construction and maintenance of accommodation, including psychosocial recovery programs specially geared towards the homeless; guaranteeing wide access to assistance centers; and widely publicizing social assistance programs
13	34,214	Between 100,000 and 500,000	Barueri (SP)	10 December 2004	0	-	-
14	34,002	500,000 +	Campo Grande (MS)	4 December 2018 (updated by a complementary law on 3 April 2019)	0	-	-
15	33,557	500,000 +	Recife (PE)	14 December 2018	0	-	-

Source: Author, 2020, from Connected Smart Cities Ranking; City master plans.

2009 and updated by a complementary law in 2015, 8th in the CSC Ranking)[26]; Niterói (PMP created in 2019, 11th in the CSC Ranking)[18]; and Rio de Janeiro (PMP created in 2011, 12th in the CSC Ranking)[21].

The following terms were used in these documents:

PSCS (one mention in São Paulo's PMP): the term is mentioned without any specific reference to the recommendations, regulations and/or guidelines set out in the PMP. It is mentioned in chart 10 in the appendix, which lists existing urban social facilities. *CHAPTER VIII, Section I, Sole paragraph – The urban social facilities are listed in Box 10 in the appendix to this law*[23].

Use of drugs and alcohol (one mention in Curitiba's PMP): *Section VI, Article 116, X – develop actions to prevent the use of drugs and alcohol, creating methods and ways of delivering specialist care, with the aim or providing effective humanized treatment under the Unified Health System (SUS)*[19].

Sanatorium (one mention in Vitória's PMP): the term is used in the context of onerous grants of the right to build (OODC). Generically, an OODC may be understood as permission (with due payment) to build over and above the lot occupancy stipulated by the master plan. *Chapter II, Section I, Article 152: In calculating lot occupancy, except for single-family residential properties, the following shall not be included: [...] IV – the area of verandas that are contiguous to rooms not exceeding: [...] b) 20% (twenty per cent) of the area of the respective room in hotel, motel, apart-hotel, pension, hospital, health and care home, sanatorium and maternity accommodation units*[24].

Specialist mental health hospitals (one mention in Brasília's PMP): *Chapter VIII, Article 52: Regional facilities are establishments in which services in the thematic areas of education, public security, health, transport, supply and culture are provided. [...] III – health: regional hospitals, specialist mental health hospitals and health surveillance units; (clause from Complementary Law 854/2012)*. Original text: *III – health: regional hospitals and health surveillance units*[25].

Mental health care (one mention in Niterói's PMP): *Chapter IV, Article 253: The guidelines set out in social development policies, which include education, health, social assistance, sport and leisure, comprise: [...] VII – broadening and promoting intersectoral actions geared towards strengthening mental health care, with emphasis on tackling crack and other drug addictions in the city's hospital units*[18].

Day centers (one mention in Niterói's PMP): *Chapter VI, Article 267. The Municipal System for the Protection of Cultural Heritage has the following objectives: [...] VII – to stimulate the revitalization of historic buildings located in ZEPAC-APAU [special cultural environment preservation zones - urban environment preservation areas] for activities geared towards older persons, such as medical clinics, day centers and health facilities in general*[18].

Psychosocial recovery (one mention in Rio de Janeiro's PMP): *SECTION III – SOCIAL ASSISTANCE, SUBSECTION II, Article 267. The Social Assistance Policy will be implemented through programs defined by the Municipal Social Assistance Council, which shall consist of: the creation, refurbishment and maintenance of assistance centers for people in need; incentives for the construction and maintenance of accommodation, including psychosocial recovery programs specially geared towards the homeless; guaranteeing wide access to assistance centers; and widely publicizing social assistance programs*[21].

It is important to highlight the mention of "mental health care" in Niterói's PMP. At first glance, it appears to be in keeping with the principles of the anti-asylum struggle and Brazil's mental health reform; however, it can be noted that, despite being created in 2019 (and therefore should theoretically address the Mental Health Reform Act and other subsequent instruments, including Ministerial Order 3088/2011[2]), the term is adopted to the detriment of "psychosocial care", as defined by the ministerial order that created PSCNs. Perhaps more important, the mention refers specifically to "tackling crack and other drug addictions", unlike the text in the aforementioned ministerial order, which talks of *mental suffering or disorders and needs arising from use*[2]. However, what is perhaps most striking is the fact that the text contains a specific mental health guideline, which, although stressing the importance of intersectoral referral, focuses on hospitals (including the Jurujuba Psychiatric Hospital – HPJ), straying from the structural principles of the mental health reform, which prioritize extrahospital resources.

With regard to the mention of "psychosocial recovery" in Rio de Janeiro's PMP, it is interesting to note that the only mention falls within social assistance guidelines specially geared towards the homeless, and is therefore outside the scope of mental health principles and guidelines.

It is also important to highlight the presence of the term "sanatorium" in Vitória's PMP, especially bearing in mind that these establishments

are considered obsolete as, just like asylums, they have been the target of severe criticism and are rigorously vilified by the anti-asylum struggle and mental health reform.

In short, in general terms, the findings show not only the timidness and weakness of mental health issues in the PMPs, but also the inadequacy of the plans in terms of the language used by the anti-asylum struggle and institutionalized in the mental health reform, which come before them.

Does this mean that the subjects and agents of the anti-asylum struggle and Brazil's mental health reform were not represented in participatory spaces during the PMP formulation process? Or did these subjects and agents not have enough political force in the participatory arena to ensure they were represented in these laws?

What is the place of the anti-asylum struggle in city planning?

How does urban-territorial planning address the implementation of residential treatment facilities (RTFs)?

We reiterate: what place do *the mad* have in the city?

However "new" these questions may seem, they have been raised in contexts of political struggle in specific municipalities across the country, such as the protests that took place in Brasília in August 2011. At the time, according to an article in the newspaper Correio Braziliense, Márcia Guiot Henning, president of the psychiatric clinic Anankê, asserted:

The mental health reform envisaged spaces in urban centers for the social inclusion of people experiencing psychic suffering, putting an end to asylums. But when the master plan was created, this transformation had not yet taken place. This needs to be reviewed. [...] We do not want these people to be marginalized all over again. We are not hospitals, we do not produce hospital waste, we have psychotherapeutic activities, like dance, art. Our role is differentiated.[26]

But what are the actual limits and possibilities of the anti-asylum struggle in PMPs?

Mental health - limits and possibilities

Upon embarking on this discussion, it is important not to lose sight of the fact that PMPs not only define urban parameters, but also address strategic zoning, planning and goal setting and, above all, the guidelines and principles to be observed by municipal plans, thus guiding a broad range of other sectors involved in the functioning of cities – such as the health sector. It is important to highlight that, although it is not mandatory to determine guidelines and principles for sectoral policies at local level, this has become a relatively well-established practice in recent decades, due to pressure from social movements in cities and new urban activism[27].

A rapid exercise in conjecture, albeit limited to the case of RTFs, shows that there are structural questions concerning consolidation and articulation in the city that recurrently come up against the following problems:

Political and ideological changes between administrations and shifts in and discontinuity of policies:

Considering the inextricable link between the consolidation and functioning of RTFs and political will and local government interests, changes in political and ideological leanings in local health departments and the coordination of mental health services give rise to a backdrop of underlying insecurity for residents, which reverberate directly in city planning and the creation and management of RTFs, thus affecting the lives of residents. The PMP's function is not to define the local government's role and responsibilities – but rather define parameters, guidelines, zoning and potential management instruments without compromising governability. Considering the PMP lifespan, RTF guidelines and principles set out in plans tend to accommodate, to some degree, to the historical political and ideological ruptures in public policy that characterize changes in administrations in the country.

Judicialization as a driver of demand:

It is common that medium and long-term planning shows shortcomings in addressing demands for RTFs, especially in municipalities where deinstitutionalization is advancing. Often, RTFs are created by governments as urgent measures in response to court decisions, with short deadlines and lack of budget flexibility. It would therefore be interesting to create specific PMP guidelines on the creation of RTFs in specific strategic zones (such as areas of special social interest, for example), that include flexible construction criteria and/or specific incentives for the private sector to provide subsidized rents. At the same time, providing for the creation of RTFs in strategic territories around the city could also ampliar exponencialmente o sentido da natureza do serviço. It would also be interesting to use urban land democratization instruments, such as progressive property tax and/or onerous grants of the right to build, in order to create other pos-

sibilities of funding the implementation of RTFs.

Difficulties in allocating public areas for the construction of RTFs:

The absence of RTFs in urban macro planning ends up producing this effect. "Health demands" end up being dealt with as issues that are exclusive to the health sector, dependent on the possibilities of the city health department. On the other hand, from an intersectoral perspective, understanding the construction of RTFs fundamentally as a housing problem would have effects not only in semiotic terms – given the importance of acknowledging these subjects as they really are: citizens with a constitutional right to housing – but also in terms of the robustness of interdepartmental planning. The possibility of recognizing people who have been discharged from asylums also as a housing shortage problem, tends to stimulate a certain level of integration between mental health policies and municipal housing plans, for example – resulting not only in extra funding possibilities, but also the definition of goals, timeframe and shared management instruments.

In contrast, trapped by their limitations, city health departments end up opting to guarantee the right by renting accommodation. However, in a significant proportion of Brazilian cities, contractual instability caused by the *nonfulfillment* of landlord (the private sector) and tenant (the government) responsibilities is not uncommon – such situations fall outside the powers of the local mental health services. Not to mention the fluctuations in rental market, which significantly affect long-term budget planning. This is central issue when calling for the mass implementation of RTFs.

It is important to underline, however, that, despite powerful potential, the dispute over urban policies involves a number of other complex issues and configurations directly linked to the efficiency of participatory spaces and the political will of governments. In short, the simple presence of these terms in PMPs is by no means a guarantee of effective implementation in practice[28]. We concur with Milton Santos:

Whether the law is actually complied with is another matter. [...] The law does not exhaust the right. The law is just a positive right, the fruit of a balance of interests, that is, of a new law. The struggle for citizenship is not exhausted in the formulation of a law or Constitution, because the law is only a concretion, a finite moment of an unending philosophical debate.[11] (p. 80).

Final considerations

This article provides initial reflections on the role cities play in anti-asylum care in liberty and psychosocial care for people experiencing mental suffering and discusses the importance of the participation of the anti-asylum struggle in the formulation of PMPs. Since deinstitutionalization and the mental health reform seek to guide psychosocial care thinking of the city, it is crucial that city planning also addresses mental health issues. In the PMPs analyzed by this study, neither the anti-asylum struggle nor mental health reform, and much less, the principle of deinstitutionalization, are satisfactorily incorporated into structural urban planning. The empirical evidence presented by this study should be problematized in order to advance and occupy urban policies, not as an end in itself, given that public and private arenas respond to determinations, processes and correlation of other forces[29,30]. Nevertheless, this is a necessary and inevitable path to ensuring that the city can be transformed into a convivial space[31] that enables care and promotes health.

It is important to consider, however, that the cities assessed under the urban quality ranking are largely located in Brazil's center-south geoeconomic region, which is the most technologically advanced, populated and developed region in the country. Except for Recife, which is placed 15th in the ranking, but is still considered a central city. The sample analyzed by this study therefore does not reflect the reality of other more peripheral cities, which therefore have their own specific experiences and have played an important role in the anti-asylum struggle – such as Bauru in São Paulo and Barbacena in Minas Gerais.

Although not included in the sample, we identified other cities that have concrete proposals for the organization of mental health in the city via the PMP, such as Janaúba in Minas Gerais, which is part of the Montes Claros intermediate region. Created in 2007, the city's PMP Section II ("Municipal Health Policy"), Subsection I ("General Processes"), Article 136 states:

The following are health policy guidelines: [...] VI. Obtain a level of service resolvability that considers rationalization with optimized service costs, as well as the effectiveness and quality of the therapeutic response, including free access to a range of existing alternative treatments and the reversal of the hospital-centric model.[32]

Finally, with regard to "city rights" (the right to liberty and the use of urban social resources), it is worth noting that the right to the city perspective extend beyond these rights, affirming the possibility of reinventing the city as the radicalization of the exercise of freedom and a horizon for raising awareness and empowering people. The right to the city is therefore the struggle for the right to a renewed urban life, taking ownership of the city as *use value* and a place of vitalizing encounters, envisioning the city as a *piece of work* (in terms of participatory activity). "The right to liberty, to individualization in socialization, to the habitat and to inhabit"[33] (p. 134). It is not an individual right, or a right to be institutionalized by the state, but rather an ethical and political platform to be constantly taken over, (re)constructed and (re)conquered by popular struggles against the logic of commodification of the city and life:

The right to the city is, therefore, far more than a right of individual access to the resources that the city embodies: it is a right to change ourselves by changing the city. [...] The freedom to make and remake ourselves and our cities is, I want to argue, one of the most precious yet most neglected of our human rights.[34] (p. 38).

Onward with the anti-asylum struggle, occupying city master plans... for the right to an anti-asylum city!

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