**Structural Vulnerability and Supplemental Security Income: Subtle Modes of Punitive Governance within Federal Social Welfare**

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Supplemental Security Income (SSI) is a United States federal welfare program examined here as emblematic of the sociostructural configurations of welfare-related deservingness and punitive governance within social welfare. We operationalize Quesada, Hart, and Bourgois’ (2011) framework of structural vulnerability to ethnographically examine people’s experience with applying for and receiving SSI in the context of a mixed-method intervention study. Our study population is comprised of HIV-positive people who use drugs and live at the nexus of extreme poverty and housing instability, serious mental illness, past or current experiences of violence and/or trauma, repeated incarceration, and lack of access to health care and social services. We found that people navigating SSI application procedures were subject to exclusionary practices at the front end of the process and punitive tactics once approved. Policies and procedures embedded within this system of social welfare not only functioned to compound existing vulnerabilities but imposed new forms of disorder, tension, and harm on individuals and their families, impacting health and mental health. We critically examine how these seemingly mundane institutional procedures are forms of structural violence that contribute to deepened vulnerability among already highly marginalized populations and the policy and programmatic recommendations resulting from applied research.

Key words: supplemental security income, drug use, structural vulnerability, structural violence, social work

**Introduction**

Anthropologists have long examined how the administration of social welfare and forms of care, broadly conceived, are often co-articulated with punitive governance in both subtle and overt forms (Auyero 2012; Fassin 2005; Fassin 2012; Ticktin 2011). In an increasingly contested political terrain in the United States, including threats to the remaining federal social safety net under the current administration, the most socially vulnerable are caught in the crossfire of debates about deservingness and personal responsibility related to health care and social welfare programs. These debates pathologize poverty, while also racializing those seeking assistance (Bell, et al. 2017; Getrich, et al. 2017; Hansen, et al. 2014). Supplemental Security Income (SSI) is a federal program managed by the Social Security Administration (SSA) that pays monthly benefits to approximately 8 million people with limited or no income who are deemed disabled, blind, or over sixty-five years old (Social Security Administration 2016). The cash benefits are meant to assist with meeting basic needs such as shelter, food, and clothing. In 2016, 6 million people met the federal classification for disability: having a medically determinable physical or mental impairment that “results in the inability to do any substantial gainful activity; can be expected to result in death; or has lasted or can be expected to last for a continuous period of not less than 12 months” (National Research Council 2007; Social Security Administration 2016).

In this manuscript, we operationalize Quesada, Hart, and Bourgois’ (2011) framework of structural vulnerability to examine the role of SSI in the lives of HIV-positive people who use drugs and live at the nexus of multiple vulnerabilities such as extreme poverty, housing instability, experiences of violence and trauma, repeated incarceration, and lack of access to health care and social services (Comfort, et al. 2015). Quesada, Hart, and Bourgois (2011:391) suggest the term vulnerability is useful to “extend the economic, material, and political insights of structural violence to encompass more explicitly…not only political-economic but also cultural and idiosyncratic sources of physical and psychodynamic distress.” More explicitly, the authors conceive of structural vulnerability as a positionality (Quesada, Hart, and Bourgois...
mental distress, and reconfigurations of how social service care and housing, increased financial hardship, increased participation in drug treatment, destabilization in medical for SSI in 1997, with substantial impacts, including: less and mental illness (Rosenheck, et al. 2000). Addiction-drugs and who also experience chronic housing instability Historically, the program was important for people who use and are materially excluded from the formal labor market. a vulnerable population in need of state-sponsored support of a “historically contingent social positioning in which inequities coalesce to shape everyday experiences” (Comfort, et al. 2015). Historically, SSI has been one of the last remaining access points into sustainable housing and health care for highly vulnerable populations (Dennis, et al. 2014; Rosenheck, et al. 2000), since it often serves as an entrée into other programs such as Medicaid and housing programs. In fact, for many people in the urban United States who are contending with multiple stigmas and social exclusions based on racialization, drug use, HIV status, or mental illness, seeking out a state-sanctioned definition of disability may be “the only way to survive” (Angell 2011) in the context of an ever-dwindling social safety net.

In this manuscript, we investigate the following questions: How is the SSI program paradoxically intertwined with structural vulnerability? Are there SSI policies and procedures that deepen vulnerability or are punitive to already vulnerable people? Our research supplements existing ethnographic literature by introducing two methodological innovations, with applied implications. First, we had an embedded key informant and research collaborator—a clinical social worker that was part of the research team—who had “clinical privilege” to move within institutional arenas that ethnographers may not always readily access (meetings with doctors, judges, and lawyers). Second, our ethnographic study operated within the context of a larger study that utilized ethnographic nuance, how SSI is inextricably concerned with improving and measuring clinical outcomes among the study population (Kral, et al. 2017; Kral, et al. 2018; Powers, et al. 2017).

SSI and Structural Vulnerability: A Key Analytic Domain

Structural vulnerability, as explicated by Quesada, Hart, and Bourgois (2011), is an adaptation of the structural violence concept (Farmer 2004a; Farmer 2004b; Galtung 1969), which refers not only to people’s inequitable material conditions but also how their experiences of vulnerability are an embodied positionality tied to discourses of worthiness, stigma, and social exclusions (Quesada, et al. 2011). SSI recipients have been officially categorized by the state as a vulnerable population in need of state-sponsored support and are materially excluded from the formal labor market. Historically, the program was important for people who use drugs and who also experience chronic housing instability and mental illness (Rosenheck, et al. 2000). Addiction-related disability was eliminated as a qualifying diagnosis for SSI in 1997, with substantial impacts, including: less participation in drug treatment, destabilization in medical care and housing, increased financial hardship, increased mental distress, and reconfigurations of how social service providers connect people with supportive services (Guydish, et al. 2003; Hogan, et al. 2010; Norris, et al. 2003; Swartz, et al. 2004). The contestation over addiction-related disability and ultimate change in eligibility criteria signals the existence of an undercurrent taxonomy of worthiness (Quesada, et al. 2011) and a moralization of people’s illicit drug use within social welfare programs.

SSI remains a key resource to combat the life or death realities of living in a state of neoliberal precarity (Wacquant 2009; Wacquant 2014), a state, as Butler (2016:25) articulates it, where some are “differentially exposed to injury, violence, and death.” Thus, the program is an anthropologically-rich analytic arena for tracing how people strategize resilience within the context of extreme social exclusion, deprivation, and violence (Auyero, et al. 2015; Biehl 2013; Bourgois and Schonberg 2009; Das 2015; Das and Randeria 2015) and how subjectivity is shaped in relation to ever-shifting state definitions of disability (Ginsburg and Rapp 2013). As recent ethnographic research has shown, being conferred SSI effectively repositions someone previously deemed a member of the “undeserving poor” into a more legitimized, state-sanctioned category of “deservingly disabled” eligible for federal welfare (Hansen, et al. 2014; Knight 2015). However, one must prove diagnosis with extreme specificity, embody qualifying conditions appropriately, and document qualifying conditions in the appropriate biomedical venues (Brodwin 2012; Hansen, et al. 2014; Knight 2015). People’s SSI eligibility is a pointed marker of their biopolitical positioning within multiple institutions—welfare, legal, and biomedical—and the categories of worthiness that must be rallied as a survival strategy when addiction is explicitly disqualified.

SSI and the “Disability Economy”

Knight (2015) aptly traces the ways in which mental illness, addiction, and suffering get rendered within a broader “disability economy” of practices governing SSI eligibility. Since the elimination of drug dependence as an eligible disabling condition, vulnerable populations and their advocates became savvy experts in this economy, leveraging particular conditions against shifting diagnostic categories. Mental illness took a principle role within the shifting economy of disability (Hansen, et al. 2014; Knight 2015), and the ability to navigate this economy (or have an advocate who does so for you) became critical survival capital. But as Hansen, Bourgois, and Drucker (2014) demonstrate, being eligible and obtaining SSI is by no means a magic-bullet stabilizing endpoint. Rather, SSI exists within the context of an economy that is also highly moralized, so that people are at once offered the promise of material stabilization but also immediately cast as suspected “cheats” within the system. These authors demonstrate, with ethnographic nuance, how SSI is inextricably tied up with processes of embodiment, as people’s options for daily survival may include having to acutely personify another stigmatized condition—e.g., being “crazy”—in order to receive benefits. This embodied vulnerability may include
defacto mandates to take psychiatric medications in order to qualify for SSI, since one has to prove they have attempted known treatment for qualifying conditions. The long-term impacts of over-medicating the structurally vulnerable is still an emerging area of research but signals a historic shift to the psychopharmaceuticalization of poverty (Biehl 2004; Hansen, et al. 2014; Knight 2015).

Methods

Research was conducted in the western and eastern neighborhoods of Oakland, California, between November 2011 and August 2013. Oakland is a mid-size city in Alameda County in the San Francisco Bay Area that experienced rapid gentrification due to the cascading effects of the tech boom. Over the course of this study, the city entered a housing affordability crisis, ranking first for the highest rent increases nationally since 2011 (BondGraham 2015). The United States Census estimates that 20 percent of people in Oakland live in poverty (United States Census Bureau 2017). When data collection for this study was active, 37,457 people in Alameda County and 936,575 people in California were receiving SSI under the category of blind and/or disabled (Social Security Administration 2013).

Ethnographic participants were sampled from a larger epidemiological study of HIV testing and treatment among people who use drugs and have criminal justice involvement ($n=2,424$). In the larger study (led by authors Lorvick and Kral), we recruited people who were eighteen years or older and had used crack cocaine or injected any drug in the last six months, using targeted sampling methods (Kral, et al. 2010; Lorvick, et al. 2015; Watters and Biernacki 1989). All participants received rapid HIV testing and completed a quantitative interview. All HIV-positive participants who were not already enrolled in HIV primary care were offered participation in an intensive case management program designed to improve enrollment and retention in HIV care.

Nineteen participants were enrolled in the case management program and ethnographic sub-study, which continued through December 2014. Participants reflected the following: 21 percent were cisgender women ($n=4$), 11 percent were transgender women ($n=2$), and 68 percent were cisgender men ($n=13$). Eighty-four percent identified as African American, while one participant identified as Latino, one participant as Native American and African American, and one participant as White. Ages ranged from twenty-six to sixty-five years. All participants were unstably housed or homeless. At the time of enrollment, the clinical social worker (author Powers) conducted a bio-psycho-social assessment, finding widespread experiences of victimization, addiction, trauma, and incarceration. Most participants had cycled in and out of incarceration and were on probation or parole. Approximately 74 percent ($n=14$) had been incarcerated at least once, and approximately 53 percent ($n=10$) had returned to jail over ten times. Details of the case management program and outcomes are described elsewhere (Kral, et al. 2017; Kral, et al. 2018; Powers, et al. 2017).

Ethnographic data collection with the case management participants (conducted by authors Lopez and Comfort) began shortly after the program launched. The goal of the ethnographic component was to evaluate participants’ experiences as they received case management and navigated key institutional contexts: HIV and acute health care settings, housing and welfare agencies, and the criminal justice system. All procedures were approved by the Institutional Review Board at RTI International. Ethnographic data were collected from the following sources: (1) weekly, audio-recorded, in-depth interviews with the social worker reviewing clinical notes by case; (2) fieldnotes from ethnographic site visits to key locations such as hospitals, shelters, and clinics; (3) field-based ethnographic interviews with participants; and (4) ethnographic fieldnotes from the social worker while working in criminal justice settings, neighborhoods, and clinical and social service spaces.

The ethnographic study design was unique because the clinical social worker served in a hybrid role, as both key informant and part of the research team. Anthropologists have a long history of collaboration with clinicians and social service providers (Lamphere 2004), and Teicher (1951) suggested that the relationship between anthropology and social work should be viewed as one of interdependence. In this study, we did not partner with an outside organization (Lamphere 2004), instead, a licensed clinical social worker conducted case management as part of our study design. The social worker did not conduct formal interviews but conducted participant observation in contexts that require clinical privilege, such as criminal justice settings and jail-based medical clinics, emergency rooms, and mental health detention facilities, enabled with formal releases signed by each participant compliant with federal guidelines. The social worker was differentially embedded as both observer and social actor with an official role in a complicated web of welfare and punitive state institutions. Her mandate was to provide case management and improve enrollment and retention in HIV care and promote viral load suppression, drawing from best practices in trauma-informed care. In the process of re-engaging participants with HIV care, applying for SSI was a first step towards stabilization.

Brodwin (2012) examines how frontline workers in a community psychiatry clinic manage aspects of the SSI system, but our social worker also operated under explicitly applied research principles. She acted as a version of what Knight (2015) coined the “neurocrat”—a social actor who ushers people through the disability economy and manages the complex arrangement in which marginality has to be biomedialized into disability categories acceptable to the state apparatus. While in Knight’s analysis, the neurocrat is a social worker who is an “advocate-cum-bureaucrat,” in our study, the social worker embodied a bidirectional role as a bureaucrat-cum-advocate with a mandate to facilitate measurable stabilization in housing, social services, and medical care. All participants who in the larger study were identified as HIV-positive and not enrolled in HIV care had

For each participant, we created a chronological case file of each interaction with the social worker and ethnographers, which included interview transcripts, ethnographic photos, institutional documents relevant to the study (e.g., SSI application forms, eviction notices), and fieldnotes. Data were structured and coded in Atlas.ti, and datasets were queried for keywords. Data regarding SSI were abstracted from the larger ethnographic dataset and analyzed at weekly meetings by a team that included a medical anthropologist, sociologist, and clinical social worker (authors Lopez, Comfort, and Powers). Data were examined as individual case studies, across case studies, and triangulated between participant observation fieldnotes and interviews conducted by each member of the analysis team (Patton 2014).

### Results

In our qualitative sample ($n=19$), seven people applied and were approved for SSI during the study. In addition, two people applied but did not receive verification as of the study end date. Participants applied based on physical disability, mental illness, and cognitive disability. During the application process, a person becomes deeply entrenched within multiple biomedical and social service regimes, a process that often radically contrasts the period of relative social abandonment (Biehl 2013) they experienced beforehand, with the exception of nearly daily engagement with the penal state (Wacquant 2009). Examining this process of entrenchment in real time using ethnographic methods proved analytically rich.

Three central findings emerged in our analysis about the relationship between the SSI system and intensified structural vulnerability. First, we found that people navigating the application process were subject to various structural barriers and exclusionary practices at the front end of the application process and experienced punitive tactics once approved. Second, we found that two key policies regarding resource limits and retroactive payments contributed to acutely enhanced vulnerability. Finally, we found that the representative payee program (for people considered incapable of managing their own benefits and who are required to identify a “payee” to manage their SSI income) lacked sufficient oversight and left recipients vulnerable to exploitation. Where one might anticipate a transition from instability to stability once SSI funds were initiated, we found that de facto exclusionary tactics, organizational irrationality, and punitive practices resulted in the introduction of new, compounded vulnerabilities because of their participation in the SSI program.

### Structural Barriers and Exclusionary Practices in Applying for SSI

The application process for SSI is complicated and required focused advocacy by the social worker, who had master’s level training and significant experience with this population. The social worker assisted in amassing the required documentation of health conditions to establish legal evidence of disability for SSA. This evidentiary process effectively biomedically recategorized applicants from “unde-serving” (e.g., “poor” and “addicted”) to more “deserving” via other forms of disability, such as mental illness or cognitive disabilities (Hansen, et al. 2014; Knight 2015).

An HIV diagnosis does not automatically confer benefits. An applicant must prove disability related to advanced HIV-related illness. Participants had to attend several appointments with SSI-approved clinicians. This lengthy process posed a challenge for two reasons unique to this population. First, people who have been unstably housed for significant periods frequently do not have a single primary care doctor or “medical home.” Due to past experiences of stigma, this population often delayed engagement with health care until a point of absolute urgency. Thus, medical records were scattered across various urgent care clinics and emergency rooms, and it required significant legwork to centralize these documents for the evidentiary process.

Interacting with clinicians and waiting in often chaotic safety-net health care settings was distressing and triggered past traumas with the health care system. For example, waiting in a hospital, one participant reflected, “This is where I came when I got shot.” Although the social worker was present to provide support in the often-invasive process of evidence gathering, these appointments could still pose distress, including hopelessness. After many years of being disconnected from primary care, one woman noted: “Being at the doctor is hard because it makes me realize how fucked up I am and how much I’ve let myself go.”

The SSI application is cumbersome and full of technical language, and it was typically impossible for the participants to fill it out alone. Several participants had previously applied for SSI on their own and been denied. Three had previously hired a for-profit attorney for assistance and been denied. The social worker provided direct assistance completing the forms but also leveraged consultation from her network. She benefitted from a “best case scenario” relationship with a non-profit legal aid center providing pro-bono legal assistance to indigent adults. These attorneys were not only technical experts but also committed to addressing the unique circumstances of this population. For instance, one participant, Ron, was experiencing an intense period of mental health decompensation and had lost contact with the social worker. Attorneys received word of an immediate hearing in front of the judge to consider an appeal for his previous SSI denial. The social worker and attorneys rapidly coordinated to sign required paperwork, and the judge ruled favorably granting retroactive payments dating back two years. It should be noted that this level of access to supportive resources was very atypical for this population. Coordination across social service and criminal justice systems was an explicit goal of the case management intervention, and many participants described how in previous attempts to apply for SSI, they had failed. This case is therefore a reflection of the hurdles that
structurally vulnerable populations face, even with access to a highly supportive case management program.

**Institutionalizing Precarity through SSI Policy: Resource Limits and Retroactive Payments**

For all participants, SSI was their only source of licit income, and no one had a network to whom they could turn for help meeting basic needs. Further, SSI benefits, though helpful, are still relatively difficult to survive on, especially in high cost-of-living areas such as the San Francisco Bay Area. When this study began in 2012, SSI monthly payments were $698, and the state of California supplemented this with $156.40, for a total monthly income of approximately $854. SSI recipients are also, by definition, managing one or more debilitating chronic conditions. Many did not have stable housing, places to cook, or safe spaces to store medication.

Two SSI policies in particular imposed chaos on the lives of participants. First, the SSA maintains strict policies on what they call “resource limits.” The amount of cash, money in bank accounts, value of owned land, life insurance, personal property, vehicles, and anything else that “could be changed to cash and used for food or shelter” constitute an applicant’s resources and cannot exceed $2,000 total for an individual. Given that one of the eligibility criteria for SSI is having a limited income, it initially seems logical that the SSA would have restrictions about existing resources. However, resource limit regulations institutionalize, as a matter of policy, peoples’ extremely precarious financial positions, since ongoing eligibility is dependent upon chronic financial deprivation. Saving money for larger needs or an emergency was severely restricted, meaning people had no “back-up” funds to store medication.

A second feature of institutionalized precarity is that when SSI is granted to someone, the start date for benefits is retroactive to the date of application. Application decisions in our study took several months, sometimes years, so when one is finally approved, the recipient may be eligible for a large retroactive payment or “back pay.” However, the way that retroactive payments intersect the policy on resource limits can produce chaotic outcomes. People received large pay-outs of money, which they could not plan to allocate slowly or save for future contingencies.

For example, Darrell, a fifty-one-year-old man, had spent most of his adult life incarcerated. Since the age of nineteen, the longest span of time that he had ever lived outside of jail was one month. He was diagnosed with HIV while in prison in 1994 and suffered from chronic pain and neuropathy. In the early 1990s, he was violently assaulted with a baseball bat, which resulted in a traumatic brain injury, which impaired his cognitive functioning. He frequently got lost or disoriented and required help to manage everyday tasks.

Deliberation by SSA took over a year, during which Darrell slept outside or in shelters while trying to manage his HIV and chronic pain. He was eventually approved and granted $40,000 in retroactive benefits. He received lump sums in amounts of $5,000 to $12,000 every six months until the balance was paid out. Given the resource limit regulations, he had to make rapid sequential purchases. He purchased an automobile that subsequently broke down and accrued numerous parking tickets. A vehicle could be very stabilizing, but when situated within Darrell’s prolonged vulnerability, since it was his only belonging, it did not substantively stabilize him. Due to his cognitive issues, he could not navigate the process of managing a bank account. He carried large amounts of cash with him, putting himself at risk for theft and assault. Further, SSI funds were loaded onto his debit card in the middle of the night—often at 12:00 a.m. or 1:00 a.m. The timing of disbursement left him vulnerable to the pull of the drug economy, and Darrell frequently went on crack cocaine and methamphetamine binges when he received his payments before he could pay for housing or other essential expenses.

**The Continuum of Exploitation Relative to Representative Payee Relationships**

Congress requires that SSA maintain the Representative Payee Program (RPP) for assisting beneficiaries deemed “incapable of managing or directing the management of his or her funds” (National Research Council 2007). SSA’s preference is to assign a family member, friend, or legal guardian to serve as a payee, though social service agencies, medical, or custodial institutions may also be selected (National Research Council 2007). Payee duties are to first use SSI payments for the beneficiary’s housing, medical care, food, clothing, and other basic needs, then to deposit remaining funds in a savings account.

In 2004, the Social Security Commissioner conducted an evaluation of the RPP to assess if payees were performing duties appropriately and to evaluate payee misuse. Findings show that there are critical gaps in payee oversight for the most at-risk beneficiaries: people with mental illness or severe disabilities, alcohol or substance use issues, and people who are homeless (National Research Council 2007). Research also illuminated inconsistent criteria by which one is mandated to have a payee and whether a judge, in consultation with a clinician, mandates a payee (Black, et al. 2008; Hanrahan, et al. 2002; Ries and Anne Comtois 1997; Rosen, et al. 2014; Rosen and Rosenheck 1999). Lack of specificity in payee policy means that assignments of payees more accurately reflect local SSI office procedures than the degree of clinical and/or social need of the recipient (Lazar, et al. 2015).

In our sample, four participants were mandated to have a payee. Their experiences ranged from one very stabilizing experience to three profoundly exploitative relationships. Three other participants were not required to have a payee, despite their extreme vulnerability. While previous studies have examined the payee assignment, to our knowledge none have done so longitudinally from the perspective of people navigating the system. We devote significant space in this
Agency-based Representative Payee: Stabilization in the Context of Extreme Adversity

Sharonda was forty-four years old and unstably housed, staying with family members intermittently or in a van with a friend. She was initially supporting herself through street-based sex work and drank heavily. She tested HIV-positive for the first time with the study and immediately applied for SSI based on mental health diagnoses with assistance from the non-profit legal aid service. She obtained various forms of qualifying evidence of mental health conditions, including letters from doctors and required psychological testing. Approximately seven months later, Sharonda was officially approved and mandated to have a payee because of her documented alcohol use. Soon after, she was approved for permanent housing through a program for HIV-positive adults.

Facilitated by the case manager, Sharonda enrolled in a money management program provided by a non-profit agency and secured a structured payee relationship even in the context of substance use and clinical depression. While the SSA noted Sharonda’s vulnerabilities, SSA staff did not directly refer her to the money management program. The payee agency helped Sharonda to open a bank account, and the agency took care of all her bills directly, including rent and utilities. She was given a cash allotment of $200 in spending money per month, and the rest was put into a savings account that she called her “cushion.” Sharonda had previously always used check cashing services, as many structurally vulnerable people do (Williams 2004), which charged exorbitant fees. She recounted that now she could cash her check “I mean, with no charge!” If Sharonda wanted additional money for a special occasion, she had to file a formal request. Sharonda embraced this process, explaining that she appreciated how it helped her to save money: “I don’t ask her [the payee] for anything I don’t need. I got to have that cushion.”

Sharonda’s history of trauma and substance use eventually led to an eviction from her apartment. Nonetheless, during this time of intense uncertainty, the payee relationship remained in place. When Sharonda was no longer paying rent, rather than increasing her monthly allotment, the agency put more money in Sharonda’s saving account. Though she would have more expenses related to homelessness (e.g., securing nightly hotel rooms), the agency still required her to go through the normal process for requesting additional funds not related to housing. Overall, utilizing a payee agency helped to stabilize her, but it was not without its challenges—Sharonda had to ride a bus for over an hour each way each time she visited them for services.

Payee Relationships within Familial or Social Networks: Exploitation, Destabilization, and Conflict

Three people in our sample who were mandated to have a payee utilized someone in their broader social or familial networks. These payee relationships ended up being either exploitative to the SSI recipient or introduced an undue burden onto family members who were themselves structurally vulnerable. Herman was a longtime SSI recipient who received benefits because he lost his eye in a car accident. After being incarcerated, a judge ordered Herman to have a payee and, in accordance with SSA’s policies, Herman chose a friend, whom SSI approved; however, the friend began to steal money from Herman immediately. At the time, Herman was living in a homeless encampment adjacent to a freeway median near a large discount store. Herman opted to change his payee, but with few options, he chose the security guard who patrolled the parking lot of the store. SSA approved this choice without question, even though Herman’s only connection to her was because of the location of his encampment.

Soon after, the security guard told Herman that the bank had seized the money, but because Herman was illiterate, he had trouble verifying the proof she offered. The social worker intervened and reported the issue to the SSA office and the police. Both said the amount lost was too small to conduct any action. Without the knowledge or resources regarding how to initiate an inquiry himself, the mismanagement of Herman’s funds might have gone unreported.

Another participant, Lewis, had a mild cognitive disability and lived in a small dilapidated trailer park. At the time of his enrollment in the study, he was out of HIV care and not taking HIV medication. After submitting the initial SSI paperwork, Lewis was informed that, in fact, he already had SSI, and his mother was listed as the payee. Lewis was not aware that he had SSI. He was also in the process of being evicted from his trailer for nonpayment. The social worker immediately reported a case of mismanagement of funds because one cannot have a payee and be under eviction for non-payment, since one of the mandates of a payee is to pay rent. The case was brought to Adult Protective Services, who initiated a full evaluation. A police report was eventually filed against his mother, who was herself struggling financially. At this point, Lewis’s partner, who was also receiving SSI benefits, reluctantly agreed to serve as his payee and manage his money.

We also found that being the payee for one’s partner can add to the burden and strain on family members who are negotiating their own vulnerabilities. Ron, a forty-six-year-old man with an AIDS diagnosis had been incarcerated for most of his adult life. The longest he had ever been in the community continuously outside of incarceration was eleven months. Early in the case management program, a psychiatrist diagnosed Ron with social phobia, paranoid type schizophrenia, generalized anxiety, depressive disorder, and auditory hallucinations. During the study, he was repeatedly incarcerated at the county jail and moved between shelters, hotel rooms, and transitional living facilities. He was routinely
denied permanent housing because of his felony convictions. Through advocacy from the social worker, Ron obtained housing in a building for people with HIV. However, there were no supportive services on site. Ron had previously applied for SSI but was denied twice, he said, because “I wasn’t sick enough. Or disabled enough,” even though he described himself as mentally and physically in “bad shape.”

On the day Ron’s SSI was approved, he was incarcerated in county jail. Ron’s pro bono lawyer visited him in jail to inform him but found Ron hiding behind a chair in a state of active paranoid psychosis. Because his SSI case had been opened years before, he was entitled to approximately $20,000 dollars of retroactive payment, subject to the resource limits policy. Ron had to spend nearly $20,000 in back pay within a year, at a moment when his mental health was extremely volatile.

Ron was mandated to have a payee and appointed Amber, his partner, with whom he has a history of domestic violence and who herself was unstably housed. Although there was never any mismanagement of his funds, having his partner serve as a payee further complicated their already fraught relationship. Ron sometimes wished he had chosen an agency payee, especially at times when he could not reach Amber. He said, “One time I called [Amber] at 12 o’clock at night—‘Hey! Is my money on my card? Get in a cab and come down!’” Through a release of information form that Ron signed, the social worker was allowed to communicate with Amber. Amber frequently contacted the social worker for support, asking for resources for “people dealing with the stresses I’m dealing with around Ron.” She ultimately lost her own permanent housing after a domestic violence incident involving Ron. She expressed feeling “used” by Ron and depression and anxiety related to managing his money. Ron was documented to have serious mental illness—these diagnoses were used as qualifying evidence in his SSI application. Yet, this did not trigger the need for oversight in payee assignment on the part of the SSA.

**Discussion**

We have profiled people who applied for or received SSI over the course of their participation in our study. Within the application phase, we found many exclusionary practices, ranging from barriers associated with complicated applications to recurring trauma and stigmatization in medical settings. These issues were only mitigated by expert legal assistance facilitated by the case management intervention. Once awarded, policies regarding resource limits and retroactive payments intersected in chaotic ways to institutionalize precarity among this already highly vulnerable population. Opportunities to use large retroactive payments to stabilize through savings accounts and long-term financial planning were prohibited as a matter of policy, thus people scrambled to spend payments to maintain eligibility. Further, the representative payee system, meant to serve as a protective mechanism, fostered destabilization through its organizational dysfunction and lack of oversight. There is ambiguity about who is mandated to have a payee and by what criteria. Family members are encouraged to be the primary choice for payees, but no account is taken regarding the suitability of family or other social contacts, increasing the risk for exploitation or undue burden upon family members. Agency-based payees can promote stabilization and mitigate the risk for mismanagement of funds, but they are not suggested or required even for people with complicated cases and compounded vulnerabilities.

Consistent with recent anthropological research on care/precarity among the structurally vulnerable (Brodwin 2012; Hansen, et al. 2014; Knight 2015; Sufrin 2017), these findings constitute examples of the specific state mechanisms through which social welfare/care is administered alongside subtle forms of punitive governance. They are institutional practices that are so seemingly mundane that they can be rendered invisible but nonetheless comprise the everyday building blocks of structural violence (Farmer 2004a) that foster structural vulnerability (Quesada, et al. 2011). The application process for SSI implicitly presumes defrauding and requires that applicants build a detailed case of deservingness based on the logics of biomedicine. This case-building requires that people who use drugs must engage with an invasive healthcare system that has been historically traumatic and stigmatizing. In this process, certain conditions that may be most debilitating in one’s life (e.g., addiction, homelessness) are marked as unworthy within the SSI taxonomy.

Though one is technically conferred a “deservingly disabled” status when awarded SSI, there are limitations imposed that uniquely impact structurally vulnerable people who use drugs. The policies governing retroactive payments and resource limits hold SSI recipients in a precarious state where they are paradoxically expected to enact personal responsibility (Bell, et al. 2017) and spend down large lump sums of money rapidly, while being prohibited from saving or owning anything worth beyond $2,000. Theses punitive mechanisms are subtly embedded within everyday institutional practices; therefore, when people “fail” to stabilize, it is more easily attributed to personal shortcomings than institutional failures. This is a form of structural violence not enacted in exceptional forms, but rather, through mundane bureaucratic modalities of punitive governance, imposed chronically, that disallow stabilization.

**Conclusion and Implications**

Our collaboration with our own “neurocrat” (Knight 2015), embedded in institutional bureaucracies as an explicit advocate, afforded us the ability to collect data about the SSI process from deep within the institutional structures where clinical privilege is required. Advocating for SSI approval and filling in the service gaps of SSA was a primary objective for people enrolled. With respect to this particular aspect of the study, we are able to propose SSI programmatic recommendations. First, the SSA should support the unique needs
of structurally vulnerable populations who use drugs. More advocates on the front end would ensure that the most vulnerable can maneuver the SSI application process. Second, at the time of SSI approval, a needs assessment should be conducted to determine if a person needs a payee, and, if so, whether they would best be served by an agency. Third, SSA policies should be attentive to how undue burden is placed on family members and friends of recipients, without compensation, for payee duties. If possible, SSA should consider whether benefits or incentives for family members who act as payees can be incorporated into the system, much like in-home support services. Fourth, SSA should keep a database of trusted payee agencies. As several cases above demonstrate, people are highly motivated to engage in money management and work towards stability if they can access a trusted, fully-vetted agency. Fifth, we also recommend further oversight by SSA on payee relationships over time, especially in the initial year of benefits. If a case of misconduct is reported, investigation should be conducted with an opportunity for recipients to be compensated for lost funds. Finally, retroactive payments should not be considered as part of resource limits. Being able to engage in saving and financial planning is a critical resource for people who have endured prolonged housing instability or homelessness and are reestablishing from an absolute zero. If someone is eligible for a large retroactive payment, connection to a trusted payee agency should be immediately facilitated.

These recommendations are aligned with a growing evidence base on “critical time intervention” (CTI), a case management model designed to help facilitate the stabilization of populations during key times of transition through establishment of care across multiple institutions (Herman 2014). In a systematic review of case management approaches for homeless adults, CTI strategies have been found to support housing stability, reduce psychiatric symptoms, and reduce substance use (De Vet, et al. 2013). This growing evidence base can be supplemented by anthropological perspectives on how the period after initial receipt of SSI is a key transitional moment that is, however counterintuitive, potentially destabilizing in the lives of vulnerable populations. Our social worker was able to facilitate coordination across social services, the criminal justice system, and the SSI system, which proved essential to mitigating (though not eliminating) some of the structural barriers our participants face.

However, these recommendations must be proposed with a caveat: when we suggest enhanced oversight and additional supportive services for structurally vulnerable people who use drugs, we are also recommending more surveillance and governance of a population already highly subjected to many institutional controls and penalization. Further, welfare-related surveillance has been shown to be highly racialized, producing enhanced injurious effects for communities of color by reinforcing existing racial hierarchies and promoting new forms of “welfare racism” (Neubeck and Cazenave 2002) wherein certain groups are either excluded from the minimal remaining benefits of the safety net or punished through a variety of mechanisms for accessing them (Morgen and Maskovsky 2003). Whereas we did not conduct a specific analysis of how race/racialization impacts the SSI application experience, given the demographics of our study sample (95% people of color), we draw from Quesada, Hart, and Bourgois’ (2011) construction of structural vulnerability, which asserts that positionality is shaped by the intersection of race/ethnicity, class, and gender, among other aspects of identity (Crenshaw 1991). Further, as critical as the above recommendations are for minimizing dysfunction in the SSI system, they must be made alongside larger anthropological questions about how we conceptualize the structures which govern people experiencing poverty and our tendency to rely solely on a “deep logic of dependency” (Brodwin 2012) as the only viable solution for structural vulnerability. In applied contexts, we must directly confront the irony that we often critique and intervene on structural vulnerability by recommending further structural dependency (Biehl and Locke 2010). Thus, we are pushed to consider how both our research questions and methodologies might shift if we work to center alternate frames (Ralph 2014) of intervention that are generated at the community level by communities experiencing vulnerability. Perhaps given structurally vulnerable populations’ deep entrenchment within these institutions as a matter of survival, pursuing these larger questions remains aspirational; however, we often assume that interventions must come from within existing structures when we could be utilizing the immense “local knowledge” (Geertz 1983) to examine the alternative structures of stabilization generated within communities that exist as corrections to the institutions that have been historically punitive to vulnerable populations.

**References Cited**


Biehl, João, and Peter Locke
2010 Deleuze and the Anthropology of Becoming. Current Anthropology 51(3):317-351.

Black, Ryan A., Bruce J. Rounsaville, Robert A. Rosenheck, Kendon J. Conrad, Samuel A. Ball, and Marc I. Rosen

BondGraham, Darwin

Bourgois, Philippe, and Jeffrey Schonberg

Brodwin, Paul

Butler, Judith

Comfort, Megan, Andrea M. Lopez, Christina Powers, Alex H. Kral, and Jennifer Lorvick

Crenshaw, Kimberle

Das, Veena

Das, Veena, and Shalini Randiera


Dennis, Deborah, Dazara Ware, and Henry J. Steadman

Farmer, Paul

Fassin, Didier


Galtung, Johan

Geertz, Clifford

Getrich, Christina M. Jacqueline M. Garcia, Angelica Solares, and Miria Kano

Ginsburg, Faye, and Rayna Rapp

Guydish, Joseph, Claudia Ponath, Alan Bostrom, Kevin Campbell, and Nancy Barron

Hanrahan, Patricia, Daniel J. Luchins, Courtenay Savage, Gail Patrick, David Roberts, and Kendon J. Conrad

Hansen, Helena, Philippe Bourgois, and Ernest Drucker

Herman, Daniel B.

Hogan, Sean R., Richard Speiglman, and Jean Cady Norris

Knight, Kelly Ray

Kral, Alex H., Megan L. Comfort, Christina Powers, Helen Cheng, Andrea Lopez, Barrot Lambdin, and Jennifer Lorvick

Kral, Alex H., Barrot H. Lambdin, Megan Comfort, Christina Powers, Helen Cheng, Andrea M. Lopez, Robert O. Murdoch, Torsten B. Neilands, and Jennifer Lorvick

Kral, Alex H., Mohsen Malekinejad, Jason Vaudrey, Alexis N. Martinez, Jennifer Lorvick, Willi McFarland, and Henry Fisher Raymond
Lamphere, Louise  

Lazar, Christina M., Anne C. Black, Thomas J. McMahan, Kevin O'Shea, and Marc I. Rosen  

Lorvick, Jennifer, Megan L. Comfort, Christopher P. Krebs, and Alex H. Kral  

Morgen, Sandra, and Jeff Maskovsky  

National Research Council  

Neubeck, Kenneth J., and Noel A. Cazenave  

Norris, Jean, Richard Scott, Richard Speiglman, and Rex Green  

Patton, Michael Quinn  

Powers, Christina, Andrea M. Lopez, Alex H. Kral, Owen Murdoch, and Jennifer Lorvick  

Quesada, James, Laurie Kain Hart, and Philippe Bourgois  

Ralph, Laurence  

Ries, Richard K., and Katherine Anne Comtois  

Rosen, Marc I., Karen Ablondi, Anne C. Black, Kristin L. Serowik, and Michael Rowe  

Rosen, Marc I., and Robert Rosenheck  

Rosenheck, Robert A., David J. Dausey, Linda Frisman, and Wesley Kasprow  

Social Security Administration (SSA)  

Sufrin, Carolyn  

Swartz, James A., Jim Baumohl, and Arthur J. Lurigio  

Teicher, Morton I.  

Ticktin, Miriam  

United States Census Bureau  

Wacquant, Loic  

Watters, John K., and Patrick Biernacki  

Williams, Brett  