

Raids, Fear, and Forgone Care: ICE Enforcement-Driven Healthcare Avoidance and Behavioral Withdrawal in Los Angeles County, 2024–2025

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Abstract

We examined longitudinal associations between exposure to Immigration and Customs Enforcement (ICE) activity, healthcare avoidance, and behavioral withdrawal in Los Angeles County (LAC), with a focus on Hispanic and foreign-born communities. We used LABarometer Survey panel data, with 1,182 respondents surveyed in both 2024 and 2025 (78% retention). ICE exposure was measured via a binary survey question capturing personal witnessing of ICE operations since January 20, 2025, and a validated 5-item behavioral avoidance scale (Cronbach's alpha = 0.90). We used weighted logistic regression, adjusting for sociodemographic, enabling, and pre-enforcement baseline controls. Hispanic identity (odds ratio [OR] = 3.08) and witnessing ICE operations (OR = 2.74) independently predicted ICE-related healthcare avoidance and withdrawal from all 5 public domains ($P < .001$). Among respondents with no prior healthcare barriers in 2024, Hispanic residents were more than 3 times as likely to avoid medical care due to ICE enforcement in 2025 (32.3% vs 9.5%; $P < .001$). ICE enforcement serves as a structural determinant of health that creates new healthcare barriers, notably independent of citizenship. Sanctuary health protections should not be contingent on individual immigration status.

Introduction

Immigration enforcement functions as a structural determinant of health, often leading to poorer self-rated health and delayed healthcare. Since Donald Trump's second inauguration in January 2025, at-large arrests and raids by Immigration and Customs Enforcement (ICE), under the Department of Homeland Security (DHS), have escalated to record levels, with at-large arrests increasing more than elevenfold since the prior administration [1]. Trump's 2024 campaign employed inflammatory rhetoric regarding immigration and the US-Mexico border, a site where he declared a national emergency under the pretext of "invasion" [2]. Alongside a series of executive orders and legislative actions targeting sanctuary protections and due process [3, 4], these policies have collectively threatened the stability and safety of the nation's immigrant communities.

Los Angeles County (LAC) has served as a national focal point of ICE activity and subsequent raids. LAC comprises more than three million foreign-born residents, mostly of Mexican descent, and about 800,000 of them are undocumented [5]. Enforcement in LAC has been characterized by show-of-force demonstrations like Operations "Los Angeles" and "Excalibur" and more than 14,000 ICE arrests in 2025 [6]. Leading architects of these policies have indicated explicitly that these raids should create a climate of fear and disruption for undocumented residents especially, such as when White House border czar Tom Homan stated on January 26, 2025, "If you're in the country illegally, you got a problem" [7]. Because enforcement concentrated in dense neighborhoods where residents share transit, clinics, schools, and public space, its consequences reach beyond those arrested into the everyday use of the urban infrastructure that health depends on. Since then, the administration has overdelivered on their promises by arresting and detaining immigrants of all statuses, altering policies regarding visas and pathways to citizenship, and committing state-sanctioned violence against U.S. citizens at the hands of ICE.

Previous scholarship has established that heightened immigration enforcement and racialized immigration policy lead to withdrawal from public programs and an increase in healthcare avoidance, especially among low-income immigrants [8]. Additionally, immigration enforcement has been shown to have spillover effects on the behaviors of those close, or of similar ethnicity, to immigrants [9]. For example, López-Cevallos and colleagues [10] provided cross-sectional evidence highlighting that experiencing discrimination in the wake of new immigration policies was associated with delaying healthcare among Latinos, regardless of citizenship status. Similarly, Friedman and Venkataramani [11] found that Hispanic citizens were less likely to report routine care attainment when ICE activity was high in their state. Meanwhile, Saadi and colleagues [12] expertly assessed the negative outcomes levied by targeted immigration investigations and arrests in healthcare settings. Testimonies of avoiding medical care and fear of deportation, among citizen and non-citizen Latinos with chronic health conditions, coherently illustrate that healthcare avoidance — as a result of intense ICE enforcement — is a distinct form of withdrawal with dire clinical consequences [12]. Novak and colleagues [13] demonstrated such consequences with their finding that, among both US-born Latina women and their immigrant counterparts, birth outcomes worsened following a major immigration raid in Postville, Iowa.

To date, most research quantifying the impact of immigration enforcement on health and healthcare avoidance has been limited to convenience sampling or cross-sectional analyses and has been unable to establish a temporal relationship between ICE enforcement and subsequent medical avoidance. While the healthcare avoidance impacts of earlier, smaller enforcement surges may have been difficult to detect in a representative sample, the size, scope, and spectacle of the 2025 surge in LA County may have produced measurable withdrawal from healthcare and other health-promoting behaviors. The current study advances the growing body of literature by using a large, representative probability sample of Los Angeles residents before and after January 2025, along with a five-item ICE behavioral avoidance scale that was developed and validated. Importantly, this study draws on pre-enforcement era panel data and demonstrates that enforcement created new healthcare barriers among residents with no prior access difficulties, providing the ability to distinguish between enforcement-driven change and pre-existing vulnerability.

We employ the Behavioral Model for Vulnerable Populations, which operationalizes “vulnerable domains (predisposing, enabling, and need) that focus on social structure and enabling resources that are especially relevant to understanding the health and health-seeking behavior of vulnerable populations” [14]. Predisposing factors include demographic characteristics along with specific vulnerable factors such as acculturation, history of incarceration, and immigration status [14]. Meanwhile, enabling factors represent facilitators to care attainment, which can be assessed, for example, through access to Federally Qualified Health Centers (FQHCs), availability of language services, and implementation of sanctuary policies. Finally, need factors represent perceived and actual susceptibility to disease and need for healthcare. This paper incorporates both traditional and vulnerable predisposing factors from the Behavioral Model for Vulnerable Populations and positions the 2025 enforcement surge as a disenabling exposure within that framework (Fig. 1). In our use of the model, the impact of immigration

status as a predisposing vulnerable factor extends beyond the individual level to affect mixed-status families and communities, especially given the spillover effects of immigration enforcement.

The current study aims to: 1) describe the prevalence and distribution of ICE-related behavioral avoidance across five public domains among LA County residents, 2) examine associations between ICE enforcement exposure, sociodemographic characteristics, healthcare avoidance, and total behavioral withdrawal by Hispanic identity and immigration status, and 3) assess whether ICE-related healthcare avoidance reflects enforcement driven change or pre-existing vulnerabilities, using longitudinal data from the matched panel.

Methods

Study Design and Sample

This research utilizes a longitudinal panel design using two waves of the LABarometer Survey administered by the Understanding America Study (UAS), a probability-based panel survey of Los Angeles County adults distributed in both English and Spanish. The 2024 wave (UAS 637, $n = 1,507$) was fielded July 24 to October 15, 2024, providing a pre-enforcement baseline before the 2025 escalation of large-scale ICE enforcement raids and operations. The 2025 wave (UAS 739, $n = 1,289$) was fielded from August 28 to November 14, 2025, and captured the health and behavioral outcomes approximately seven to ten months into the enforcement surge. UAS post-stratification weights were applied throughout all analyses using the `svyset` command in Stata 18 to be representative of the Los Angeles County population while accounting for survey design effects.

The 2025 wave included 1,289 LAC residents. From that sample, 1,182 participants had also previously completed the 2024 wave. This resulted in a matched longitudinal panel with 78% year-to-year retention (1,182 panel respondents out of 1,507 in the 2024 wave). Five zero-weight observations were excluded automatically by `svy`. Due to item-level missingness across respondents, analytical samples from the matched panel range from 1,141 to 1,157.

Measures

Exposure to ICE enforcement was measured through two indicators. First, direct witnessing of enforcement was assessed using a binary survey item. The item asked if participants had personally witnessed operations in LAC since January 20, 2025, including arrests, questioning, vehicle stops, or raids conducted by officers identified as ICE, HSI (Homeland Security Investigations), or ERO (Enforcement and Removal Operations). Second, ICE-related avoidance behavior was assessed by a five-item scale (each item was binary, 1 = avoided, 0 = did not avoid or not sure) that measured participants' avoidance of needed medical care, work or school, public places, public transportation, and legal services because of concern about recent safety events in LAC (`ice003a-e`). Both were administered as part of an explicit ICE module in the 2025 wave. The primary outcome was avoiding needed medical

care. A composite avoidance count (range 0–5) summed the five binary responses, and total behavioral withdrawal was defined as avoiding all five public domains simultaneously.

The psychometric properties of the five avoidance items were assessed prior to formal data analysis. Internal consistency was high (Cronbach's alpha = 0.90), and principal component factor analysis retained a single factor (eigenvalue = 3.77, 62.8% of variance explained) with item loadings ranging from 0.80 to 0.88. ICE witnessing loaded at 0.42 on the same factor, with a uniqueness of 0.82, indicating substantial empirical distinctiveness from the avoidance behaviors and supporting its use as an exposure variable rather than a scale component.

Baseline measures from the pre-enforcement era in the 2024 wave were linked to the 2025 wave post-enforcement era outcomes among matched panel respondents. The 2024 wave measures derived included: self-rated health (scale of 1 “excellent” to 5 “poor”), any healthcare delay in the past 12 months (binary), mental health care delay in the past 12 months (binary), and PHQ-4 score (items scored 1–4, range 4–16, not the conventional 0–12). These measures were used as controls in the fully adjusted models and as stratifying measures in the Aim 3 longitudinal analysis.

Sociodemographic controls follow the Behavioral Model for Vulnerable Populations. Predisposing factors included age (continuous), Hispanic identity (binary), first-generation immigrant status (binary), and citizenship status (noncitizen binary). Enabling factors included insurance status (uninsured binary). Need factors included self-rated health in 2025 and the pre-enforcement baseline controls described earlier.

Statistical Analysis

All statistical analyses were performed using Stata 18. We first estimated three weighted logistic regression models for healthcare avoidance and total behavioral withdrawal. The first model (M1) is restricted to structural factors only (Hispanic identity, first-generation immigration status, legal status, ICE witnessing, and age). The second model (M2) adds enabling and need controls (insurance status and self-rated health in 2025). The third (M3), and longitudinal model, incorporates pre-enforcement baseline controls from the 2024 wave. This approach, informed by Gelberg and colleagues' [14] Behavioral Model for Vulnerable Populations, was similarly applied by López-Cevallos and colleagues [10]. Further, we estimated a weighted OLS model using avoidance count as a continuous outcome. Lastly, for Aim 3, we restricted the analytic sample to respondents with no prior healthcare barriers and examined healthcare avoidance in 2025 by Hispanic identity using design-based F tests, whose denominator degrees of freedom derive from the survey design, not the subgroup size. PHQ-4 outcomes are reported descriptively by exposure group; in lagged models adjusting for baseline PHQ-4, enforcement exposure was not associated with 2025 distress. Avoidance behaviors were not included simultaneously as predictors due to high intercorrelations ($r = 0.56\text{--}0.79$), therefore we opted to model each outcome separately.

Results

Table I presents the sample characteristics of the matched longitudinal panel, which comprised 1,182 LA County adults (due to item-level missingness, analytic samples ranged from 1,156 to 1,157 for descriptive outcomes and from 1,141 to 1,145 in the fully adjusted models). The unweighted sample yielded a mean age of 49.8 years (SD = 15.2), with Hispanic and Latino residents accounting for 39.6% of the analytic sample. First-generation immigrants and non-citizens constituted 22.3% and 7.3%, respectively. The sample was majority female (60.9%) and college-educated (51.2%). Descriptive statistics are unweighted; all regression estimates are survey weighted.

Baseline health measures from the 2024 wave reflect structural vulnerability among respondents, as 26.0% reported delaying healthcare in the previous year, with 7.8% attributed to mental healthcare specifically. Then, in the 2025 wave, about one in four participants (22.3%) reported personally witnessing ICE operations in LA County since January 20, 2025. Also in 2025, 15.7% of respondents avoided all five public domains simultaneously, 19.4% avoided seeking needed medical care, 39.3% avoided public places, 33.5% avoided public transit, 27.2% avoided work or school, and 23.0% avoided legal services.

The inter-item correlations among the five avoidance domains ranged from $r = 0.56$ – 0.79 , illustrating that the covariates moved together, albeit not perfectly. ICE witnessing was more weakly correlated with each avoidance item ($r = 0.25$ – 0.29), suggesting it measured a related but distinct construct.

The composite avoidance count correlated with the factor-derived score at $r = 0.99$. As shown in Fig. 2, all six ICE exposure measures were significantly more prevalent among Hispanic/Latino respondents than among their non-Hispanic counterparts ($P < .001$); the primary outcome, medical care avoidance, was 33.5% versus 10.8%.

The relationship between Hispanic identity and avoidance revealed a dose-response gradient, as Hispanics comprised 31% of those who avoided no public domains while accounting for 69% of the total withdrawal group ($\chi^2 = 101.1$, $P < .001$).

Descriptive analysis showed elevated psychological distress among ICE-exposed respondents in 2025 (PHQ-4 6.93 vs 6.12, $P < .001$) and among the total withdrawal group (7.26 vs 6.12, $P < .001$). These contrasts are unadjusted; in lagged models controlling for baseline PHQ-4, enforcement exposure was not associated with 2025 distress ($P = .69$).

Weighted logistic regression results for healthcare avoidance and total behavioral withdrawal are presented in Table II, and remained stable across all three model configurations. In the least specific regression model (M1), Hispanic identity and witnessing ICE operations in LAC were both associated with about 3 times the odds (OR = 3.14, 95% CI: 2.09–4.70, $P < .001$; OR = 2.94, 95% CI: 1.94–4.47, $P < .001$) of avoiding medical care. The intermediate model (M2), which adjusted for enabling and need controls, produced minimal attenuation (Hispanic OR = 3.15, ICE witnessed OR = 2.90). The fully adjusted

longitudinal model (M3), incorporating the pre-enforcement controls from the 2024 wave, yielded nearly identical estimates (Hispanic OR = 3.08, ICE witnessed OR = 2.74, both $P < .001$). Neither citizenship nor insurance coverage significantly predicted medical care avoidance in any of the three regression models, though the small number of non-citizens ($n = 84$) limits precision for that estimate.

Results for total behavioral withdrawal followed the same pattern. Across all three models, Hispanic identity (OR range: 3.14–3.40) and ICE witnessing (OR range: 2.78–2.92) independently predicted withdrawal from all five public domains. M3 revealed that pre-enforcement poor self-rated health also predicted total withdrawal in the enforcement era (OR = 1.81, $P < .01$).

In the OLS model using avoidance count as a continuous outcome, witnessing ICE enforcement was associated with avoiding 1.19 additional domains of withdrawal ($b = + 1.19$, $P < .001$), Hispanic identity with 0.81 additional domains ($b = + 0.81$, $P < .001$), and first-generation immigrant status with 0.41 additional domains ($b = + 0.41$, $P = .01$).

The panel design provides the ability to distinguish enforcement-driven healthcare avoidance from pre-existing access patterns. We restricted the analytic sample for the longitudinal analysis to respondents who did not report any healthcare barriers in 2024 ($n = 853$). Among this subgroup, Hispanic residents were significantly more likely to avoid medical care in 2025 than non-Hispanic residents (32.3% vs 9.5%, $F(1, 1165) = 46.71$, $P < .001$), a more than threefold difference among respondents for whom the barrier was genuinely new (Fig. 2). A second baseline indicator, no prior mental health delay ($n = 1,051$), provided consistent results: Hispanic residents reported significantly higher medical care avoidance in 2025 than non-Hispanic residents (31.8% vs 10.1%, $F(1, 1163) = 50.66$, $P < .001$).

Discussion

This study examined whether the unprecedented escalation of ICE operations in 2025 produced measurable and comprehensive behavioral withdrawal from public life in LAC, and whether that withdrawal is reflective of pre-enforcement vulnerabilities or the result of ICE-driven change. Three core findings emerged consistently across the analyses.

First, immigration enforcement was associated with a generalized retreat from public life. The five ICE avoidance domains (public places, healthcare, transit, work/school, and legal/governmental services) formed a reliable, coherent scale (Cronbach's alpha = 0.90). In tandem, factor analysis revealed that witnessing ICE was empirically distinct from the five avoidance items (loading = 0.42, uniqueness = 0.82), supporting the notion that witnessing ICE alone was not sufficient to induce withdrawal unless other predisposing factors like race/ethnicity and immigration status were also in play.

Second, both Hispanic identity and direct ICE witnessing independently predicted healthcare avoidance, in addition to total behavioral withdrawal, across all three weighted models. The findings were robust to enabling factors and to pre-enforcement baseline health measures from the 2024 wave. This stability

suggests that ICE-driven avoidance is not attributable to financial barriers or pre-existing health vulnerabilities, but to community-level fear.

Third, and most importantly for causal inference, the longitudinal panel design indicated that enforcement created new healthcare barriers rather than exposing pre-existing ones. Among respondents who had not delayed care in the year before the enforcement surge, Hispanic residents were more than 3 times as likely to avoid medical care in 2025 than non-Hispanic residents, replicated across two independent baseline restriction criteria. This finding rules out prior healthcare barriers as an explanation and represents the study's most direct evidence that the 2025 enforcement surge, rather than pre-existing structural disadvantage, is the proximate driver of healthcare avoidance among Hispanic LA County residents.

These results are consistent with and extend the growing body of scholarship on immigration enforcement and health. The most directly comparable study is by López-Cevallos and colleagues [10], who found that among a nationally representative sample of Latino immigrant adults, experiencing discrimination was associated with healthcare avoidance. The current study provides more specific effects by capturing direct personal witnessing of enforcement operations rather than perceived discrimination.

The findings further extend Friedman and Venkataramani's [11] quasi-experimental study, which found that intensified enforcement was associated with reduced likelihood of Hispanic adults reporting a primary care provider and an annual checkup, with no parallel effect among non-Hispanic adults. This study replicates and deepens that Hispanic-specific pattern using individual-level data from a county that served as a national epicenter of the 2025 surge. Darney and colleagues similarly found that more exclusionary state immigration policy climates were associated with lower use of effective contraception among both US-born and foreign-born Mexican-origin women, consistent with harm extending beyond those directly targeted by enforcement [15]. Young and colleagues similarly report that cumulative enforcement encounters predict delayed care among Latinx and Asian immigrants [16].

A consistent methodological critique of the largely cross-sectional research in this area is that observed disparities in healthcare avoidance may reflect pre-existing patterns rather than enforcement-driven change. Hispanic communities in LAC face fear, trauma, and structural barriers to healthcare that predate January 2025 by decades, including the historical underfunding of safety-net institutions, linguistic isolation, and the non-consensual sterilization of Latina women at Los Angeles General Hospital in the 1970s [17]. While these historical traumas may indeed resonate, the use of a longitudinal panel design establishes that even when restricted to a group of people who had not reported a healthcare delay in the previous round, Hispanic respondents were more than 3 times as likely to avoid healthcare after the 2025 ICE activity surge. In 2024, ICE enforcement at its current scale did not exist as a contextual condition shaping healthcare-seeking behavior in this subgroup; by 2025, it did, functioning as a disabling exposure under the Behavioral Model for Vulnerable Populations framework. The finding is not readily explainable by pre-existing vulnerability, because the subgroup was selected

specifically to exclude it. It remains possible that the groups differed on characteristics the panel did not measure, and that some other variation amongst Hispanic and foreign-born respondents, such as medical need, may have determined why some individuals delayed or withdrew while others did not.

Enforcement harm was also not distributed randomly. Respondents with worse pre-enforcement self-rated health were substantially more likely to withdraw from all five domains of public life simultaneously. While self-rated health is not a perfect measure of need, this finding runs contrary to the notion that healthcare avoidance may have occurred amongst those with fewer medical needs. If anything, the burden of withdrawal affected those with higher needs on average.

These findings have direct implications for policy at multiple levels. Sanctuary health policies, meaning explicit institutional commitments to protect healthcare access regardless of legal status, represent the most immediate lever available to health facilities across LAC [12]. FQHCs, historically exempted from PRWORA's 1996 immigrant benefit restrictions until that exemption was narrowed in 2025, should be protected and expanded in enforcement-affected neighborhoods. Clinical settings should develop explicit ICE-response protocols, including staff training, removal of immigration status from intake forms, and policies requiring judicial warrants before cooperating with enforcement. Community health navigator programs and even field-based medicine in high-enforcement neighborhoods offer an approach to bridging the gap between need and utilization. Yet such efforts may be hampered by ongoing cuts to Medicaid, which have both threatened FQHCs and forced some individuals out of Medicaid coverage. Lastly, this study provides an empirical baseline against which to monitor the health consequences of the HR1 One Big Beautiful Bill Act's planned expansion of ICE capabilities.

Limitations

This study is not without limitations. First, the data only reflect the experiences of one US county. Studies are needed at different scales of analysis and in other locations, particularly those with more exclusionary state and county legal environments [18].

Second, exposure to ICE enforcement and resulting healthcare avoidance were self-reported. The stress and trauma of increased enforcement may make recall more biased, and because exposure and outcome share a reporting source, this could inflate rather than attenuate the association. Because residential identifiers and individual health records were unavailable, and community-documented enforcement incidents are limited in scope, it was not possible to validate self-reports of these experiences. Future analyses should include neighborhood-level spatial analysis and health records to provide a stronger causal argument.

Finally, 22% of respondents (n = 325) did not complete the 2025 wave, leaving the study vulnerable to moderate selection bias. If respondents most affected by enforcement were most likely to disengage from the panel, the magnitude of exposure would be understated.

Conclusions

The data presented in this study coherently illustrate immigration enforcement as a disruptive – and selective – catalyst of fear, withdrawal, and worsening health. Therefore, we find it imperative that healthcare access not be contingent on legal status. Concretely, this includes ending local law enforcement collaboration with ICE, investing in culturally grounded mental health care, legal aid, housing stability, worker protections, and food access, and funding the community organizations that immigrant residents already trust to deliver accessible health.

Priorities for research include geographically linking respondent data to independently gathered enforcement incident data, and longer longitudinal follow-up to determine whether these new access barriers produce measurable downstream clinical consequences.

Communities most affected by enforcement should be involved as partners in defining what harm means and what recovery entails.

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Tables

Table I Sample Characteristics by Total Behavioral Withdrawal and Avoided Medical Care (ICE) Among LA County Adults, UAS 739 (2025)

	Total Behavioral Withdrawal			Avoided Medical Care (ICE)		
Characteristic	No (N=975)	Yes (N=181)	Total (N=1156)	No (N=932)	Yes (N=225)	Total (N=1157)
Continuous Variables						
Age, mean (SD)	50.7 (15.3)	44.8 (13.7)	49.8 (15.2)	50.8 (15.3)	45.6 (14.1)	49.8 (15.2)
Sociodemographic Characteristics						
Hispanic/Latino, n (%)						
No	642 (65.8%)	56 (30.9%)	698 (60.4%)	622 (66.7%)	77 (34.2%)	699 (60.4%)
Yes	333 (34.2%)	125 (69.1%)	458 (39.6%)	310 (33.3%)	148 (65.8%)	458 (39.6%)
First-Generation Immigrant, n (%)						
No	716 (73.4%)	119 (65.7%)	835 (72.2%)	687 (73.7%)	149 (66.2%)	836 (72.3%)
Yes	259 (26.6%)	62 (34.3%)	321 (27.8%)	245 (26.3%)	76 (33.8%)	321 (27.7%)
Non-Citizen, n (%)						
No	911 (93.4%)	161 (89.0%)	1072 (92.7%)	870 (93.3%)	203 (90.2%)	1073 (92.7%)
Yes	64 (6.6%)	20 (11.0%)	84 (7.3%)	62 (6.7%)	22 (9.8%)	84 (7.3%)
ICE Enforcement Exposure						
Witnessed ICE Operations, n (%)						
No	804 (82.5%)	94 (51.9%)	898 (77.7%)	775 (83.2%)	124 (55.1%)	899 (77.7%)
Yes	171 (17.5%)	87 (48.1%)	258 (22.3%)	157 (16.8%)	101 (44.9%)	258 (22.3%)
Health Status and Mental Health						
PHQ-4 Sum 2025 (4–16), mean (SD)	6.1 (2.7)	7.3 (3.7)	6.3 (2.9)	6.1 (2.7)	7.3 (3.7)	6.3 (2.9)
PHQ-4 Sum 2024 Baseline (4–16), mean (SD)	6.2 (2.9)	7.0 (3.6)	6.3 (3.0)	6.2 (2.9)	7.0 (3.5)	6.3 (3.0)
Healthcare Access and Pre-Enforcement Barriers						

	Total Behavioral Withdrawal			Avoided Medical Care (ICE)		
Characteristic	No (N=975)	Yes (N=181)	Total (N=1156)	No (N=932)	Yes (N=225)	Total (N=1157)
Uninsured, n (%)						
No	919 (94.3%)	169 (93.4%)	1088 (94.1%)	878 (94.2%)	211 (93.8%)	1089 (94.1%)
Yes	56 (5.7%)	12 (6.6%)	68 (5.9%)	54 (5.8%)	14 (6.2%)	68 (5.9%)
Any Healthcare Delay 2024, n (%)						
No	735 (75.4%)	121 (66.9%)	856 (74.0%)	708 (76.0%)	148 (65.8%)	856 (74.0%)
Yes	240 (24.6%)	60 (33.1%)	300 (26.0%)	224 (24.0%)	77 (34.2%)	301 (26.0%)
Mental Health Care Delay 2024, n (%)						
No	900 (93.4%)	154 (86.0%)	1054 (92.2%)	865 (93.9%)	190 (85.2%)	1055 (92.2%)
Yes	64 (6.6%)	25 (14.0%)	89 (7.8%)	56 (6.1%)	33 (14.8%)	89 (7.8%)
Everyday Discrimination Sum (4–25), mean (SD)	7.1 (3.2)	7.8 (4.0)	7.2 (3.3)	7.1 (3.2)	7.7 (3.9)	7.2 (3.3)

Note: Frequencies and row percentages for categorical variables; means and standard deviations (SD) for continuous variables. Total columns show sample composition. Unweighted distributions shown; all regression models use UAS post-stratification weights. Group differences tested by chi-square; all $P < .001$ except non-citizen status ($P = .11$)

Table II Weighted Regression Models (Model 3, Fully Adjusted): Predictors of ICE-Related Healthcare Avoidance, Total Behavioral Withdrawal, and Avoidance Count Among LA County Adults (UAS 739, 2025)

Predictor	Healthcare Avoidance	Total Withdrawal	Avoidance Count (b)
	<i>OR [95% CI]</i>	<i>OR [95% CI]</i>	<i>b (SE)</i>
Hispanic/Latino	3.08***	3.14***	0.81***
<i>[95% CI] / (SE)</i>	<i>[2.05, 4.61]</i>	<i>[1.98, 4.97]</i>	<i>(0.15)</i>
Witnessed ICE Operations	2.74***	2.78***	1.19***
<i>[95% CI] / (SE)</i>	<i>[1.80, 4.18]</i>	<i>[1.77, 4.37]</i>	<i>(0.17)</i>
First-Generation Immigrant	1.85*	1.82*	0.41*
<i>[95% CI] / (SE)</i>	<i>[1.15, 2.99]</i>	<i>[1.06, 3.10]</i>	<i>(0.16)</i>
Self-Rated Health 2024	1.38†	1.81**	0.18
<i>[95% CI] / (SE)</i>	<i>[0.94, 2.02]</i>	<i>[1.24, 2.64]</i>	<i>(0.12)</i>
Mental Health Delay 2024	2.21†	1.55	—
<i>[95% CI] / (SE)</i>	<i>[0.99, 4.91]</i>	<i>[0.68, 3.52]</i>	—
Observations	1,142	1,141	1,145

† $P < .10$ * $P < .05$ ** $P < .01$ *** $P < .001$. Estimates are from the fully adjusted longitudinal model (M3); M1 and M2 estimates are reported in the Results. Prior healthcare delay in 2024 was included in M3 and predicted neither outcome (healthcare avoidance $OR=1.02$, $P=.94$; total withdrawal $OR=0.99$, $P=.96$).

Figures

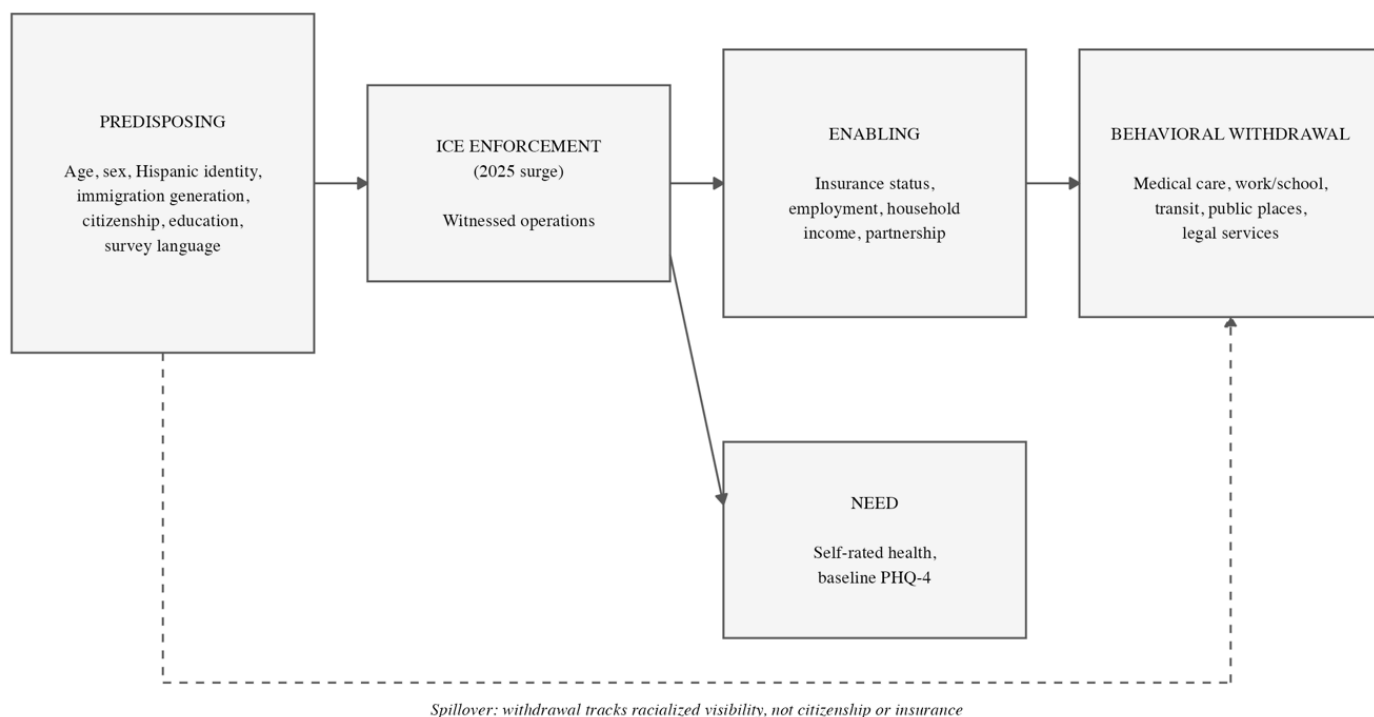


Figure 1

Conceptual model of ICE enforcement as a disenabling exposure, adapted from the Behavioral Model for Vulnerable Populations, Los Angeles County, 2024–2025

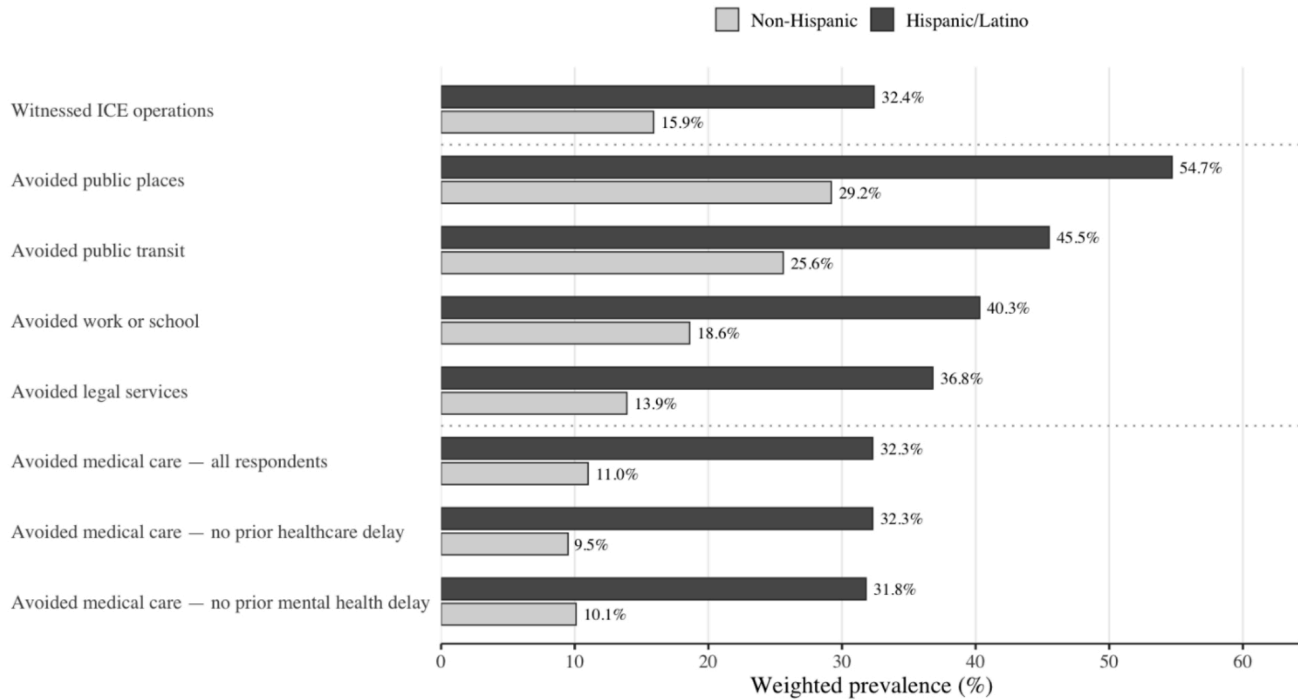


Figure 2

Weighted prevalence of ICE enforcement exposure and behavioral avoidance by Hispanic/Latino identity, Los Angeles County, 2025

Note. Weighted proportions using UAS post-stratification weights; n=1,156 matched panel respondents. Dotted lines separate enforcement exposure (top), avoidance across public domains (middle), and medical care avoidance overall and among respondents reporting no healthcare delay (n=853) or no mental health care delay (n=1,051) in the 2024 wave. All group differences $P<.001$ (chi-square tests).