Supplemental File: Worries, Attitudes, and Mental Health of Older Adults during the COVID-19 pandemic: Canadian and US Perspectives

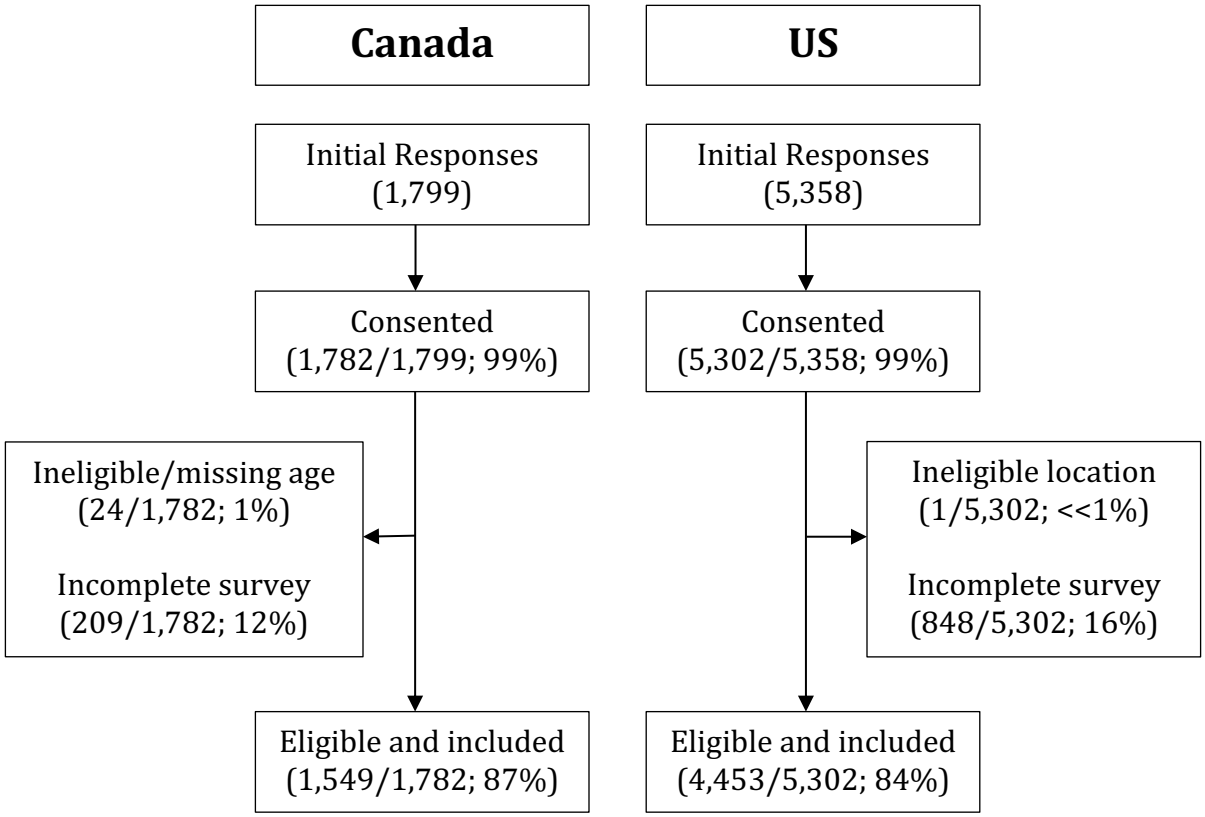
Supplementary Text S1: Additional Methodology Details

The survey completion rate was calculated as the number of respondents who finished the survey divided by the number of respondents who consented to participate. For US data we excluded surveys with >65% missing data. For Canadian data we excluded surveys if age was missing, if respondents were younger than 55, or if respondents did not go beyond providing demographic information. IP addresses were removed if they were outside the US or Canada. Missing data was defined differently due to the fact that the Research Ethics Board (REB) in Canada did not allow for mandatory questions, whereas the US Institutional Review Board (IRB) permitted mandatory age and demographic questions in order to complete the survey. We used adaptive questioning for certain items (i.e. some questions conditionally displayed based on earlier responses) to reduce the number and complexity of the questions. Qualtrics software did not allow for completeness checks prior survey submission and there were very few mandatory items due to REB specifications. Respondents were able to review and change their answers through the back button before submitting the survey.

The 5-point Likert-type questions to assess COVID-19 perceptions and attitudes towards government response were developed by authors at the University of Michigan in consultation with survey methodologists at the Survey Research Center,

University of Michigan Institute for Social Research. These questions had response options that were based on the most commonly used Likert scales asking respondents to indicate their degree of agreement with a declarative statement.[1] The questions asked "To what extent do you agree or disagree with the following statements? [strongly agree, agree, neither agree nor disagree, disagree, strongly disagree]". The eight-item CES-D has been used in the US Health and Retirement Study and has high internal consistency and reliability[2,3]. We used a score ≥3 to define elevated depressive symptoms, which was determined to be similar to the cut point of ≥16 on the full CES-D[3] and has been used in prior research with older adults[4]. The 5-item BAI has been used in other studies of older adults with good internal consistency[5]. We defined elevated anxiety as scores ≥10 on the 5-item BAI, corresponding to the highest quartile of the distribution in our sample, which is a similar justification of cut-off scores used by Gould et al.[6] Loneliness was measured using the 3-item UCLA-loneliness scale, a validated, self-rated tool with illustrated reliability and correlation to the full 20-item revised UCLA loneliness scale[7]. A total score of ≥6 was considered lonely, similar to other epidemiologic studies of older adults[8,9]. All three mental health scales had good internal consistency, with Chronbach's alpha of 0.82 (both US and Canada) for the 8-item CES-D, 0.75 (US) and 0.76 (Canada) for the 5-item BAI, and 0.77 (US) and 0.78 (Canada) for the 3-item UCLA loneliness scale.

Supplementary Figure S1: Recruitment flow chart



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