attenuated, whereas residual-based CR preserved its effect on depressive burden (HR [fully adjusted model]: 0.59; 95% CI: 0.40-0.88). Next steps include evaluating the ability of reserve measures to attenuate the association of brain integrity with depressive burden using interaction analysis.

Conclusion: Preliminary findings suggest that CR may be linked with depression development in older adults, although the association may vary depending on measurement of reserve. Association of activity- based reserve may be attributed to somatic disease pathways.

FC35: Depressive symptom transitions in older adults: effects of psychosocial, behavioral, and clinical factors

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Objective: Depression evolves dynamically in old age. Studies of natural history of major depression in older adults suggest that 19–34% recover, 27%–32% remain chronically ill, and approximately 40% experience a fluctuating course. Another way of approaching depression from a longitudinal point of view is by adopting a symptom-based approach, that in addition to the evolution of clinically manifested diagnostic entities, also focuses on transitions involving subclinical/subsyndromal states, although few studies have attempted it. We examined psychosocial, behavioral, and clinical determinants of transitions across states that include no depression, subsyndromal-, and clinical depression.

Methods: We used data on 3086 adults aged 60+ from the Swedish National Study on Aging and Care in Kungsholmen, followed for 15 years. Markov-state transition models were used to capture transition patterns, as well as their associated determinants. Death and dropout constituted absorbing states. Depression was diagnosed in accordance with DSM-5; SSD was based on having at least 2 symptoms in the absence of DSM diagnosis. Determinants of transition patterns included index of social connections and support (i.e., psychosocial determinants); smoking, alcohol consumption, and physical activity (behavioral determinants); somatic disease burden and history of depression (clinical determinants).

Results: At baseline, 10% of the study population exhibited clinically relevant levels of depressive symptoms. Over a 15-year period, a total of 11,489 transitions were observed. Preliminary results indicate that behavioral factors (primarily smoking) were mostly associated with transitions from no depression to clinical depression, as well as from clinical depression to death. Mostly the same pattern was seen for clinical determinants, although higher burden of chronic diseases and previous depression also increased the likelihood of transition from no depression to SSD. Notably, of high baseline values of social connection and support were found to: 1) lower the likelihood of transitioning from no depression to either SSD or clinical depression; 2) lower the likelihood of transitioning from SSD to clinical depression; and 3) increase the likelihood of transitioning from clinical depression to no depression.

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Conclusion: Clinical and behavioral factors are mostly implicated in lowering the occurrence of depression, whereas psychosocial factors may also be implicated in recovery.

FC36: Social determinants of modifiable dementia risk in Maori and Non-Maori: Results of the New Zealand Health, Work and Retirement study

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Background: Dementia risk varies along the social gradient, which needs to be considered in risk reduction and prevention strategies. Revealing links of social determinants of health (SDOH) and modifiable health and lifestyle factors for dementia holds clues towards maximizing dementia risk reduction opportunities, especially for vulnerable populations. Therefore, the aim was to investigate associations of SDOH and a dementia risk score in Indigenous Māori and Non-Māori (mainly European descent) in midlife and early late-life.

Method: A subsample of the New Zealand Health, Work and Retirement study completed standardized face-to-face cognitive assessments (adapted 'Kiwi' Addenbrooke's Cognitive Examination/ACE-R) in 2010. We computed the Lifestyle for Brain Health (LIBRA) dementia risk score, comprising 8 risk factors (low/moderate alcohol consumption, heart disease, physical inactivity, chronic kidney disease, diabetes, smoking, hypertension, depression). Higher scores indicate higher dementia risk/poorer lifestyle (range= -1;+9.2). First, we assessed associations of LIBRA and cognition. Second, we performed adjusted regression analysis for area-based (socioeconomic deprivation, health care access, neighbourhood safety) and individual SDOH (education, employment status, net income, social loneliness) with LIBRA stratified for Māori and Non-Māori.

Results: In 918 participants (age: *M*= 62.9 years, *SD*= 6.7, range= 48-75; females= 52.8%; Māori= 26.2%), a higher LIBRA score (*M*= 1.8, *SD*= 1.6, observed range= -1; +7.4) was associated with lower cognitive functioning (b= -0.30, 95%CI= [-0.48;-0.11], *p*= .002) and cognitive impairment (OR= 1.41, 95%CI= [1.10;1.81], *p*= .007), adjusted for age, sex, education, ethnicity and area-based socio- economic deprivation. Higher area-based socio-economic deprivation was associated with higher LIBRA in Māori (b= .10, 95%CI= [0.02;0.18], *p*= .020), but not in Non-Māori (b= 0.01, 95%CI= [- .03;0.05], *p*= .677). Employment status and lower neighbourhood safety were associated with higher LIBRA in Non-Māori only. Health care access difficulties and social loneliness were associated with higher LIBRA in both populations, while education and net income were not.

Conclusion: SODH are differentially associated with dementia risk in midlife and early late-life New Zealanders. Area-based socioeconomic deprivation was linked to dementia risk in Indigenous Māori, but not in Non-Māori. This points to systematic inequities in dementia risk, which require equity- focused policy-based public health approaches to risk reduction.

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