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Cohort Profile

Cohort Profile: Growing up in Australia: the Longitudinal Study of Australian Children (LSAC)

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Key Features

- The Longitudinal Study of Australian Children was allocated Australian Government funding in 2000 and data collection commenced in 2004. It was the first Australian nationwide child cohort study designed to provide insights into the contemporary family, economic, social service, and policy factors affecting children's life-course trajectories.
- Two nationally representative cohorts were recruited in 2004: the Baby (B) cohort aged 0–1 years ($N=5107$) and the Kindergarten (K) cohort aged 4–5 years ($N=4983$).
- Main waves of data have been collected every 2 years, resulting in 10 main waves of data collection by 2024. Parents, teachers, and, in later waves, children/young people report on a broad range of outcomes and influences on health and development over the lifespan. The dataset is enriched through initiatives such as the linkage of administrative data, time-use diaries, and direct assessments.
- The study remains highly generative for new knowledge, particularly as data are just becoming available on outcomes salient to young adult's health, wellbeing, and participation, such as education, employment, and family formation.

Why was the cohort set up?

In 2000, the Australian Government announced its intention to develop a national longitudinal study of children and their families, and funding was allocated for this endeavour. Since the 1980s, evidence from the biological and social sciences had

accumulated on the importance of the early years in shaping individual capabilities that promote wellbeing across the life course [1, 2]. Integrated ecological life-course approaches have now provided the theoretical bases for understanding the risk and protective factors operating and their impact over

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time [3]. Reflecting this, policy discussions in Australia began to acknowledge the diverse ecological influences on child development across health, socio-emotional, cognitive, and academic outcomes. It was also recognized that Australia had no child cohort studies with a sufficiently large, nationally representative sample to address contemporary policy concerns [1]. Through the combined advocacy efforts of many individuals and groups across academia and policy, Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC) was established. The sampling frame and the foci for measurement were developed throughout 2001–2003. The study was launched in February 2004 and is now housed at the Australian Institute of Family Studies—a national government agency.

The broad aims of LSAC were to:

- i) document how well Australian children were faring on key life-course outcomes;
- ii) identify the characteristics of children and their environments that impact outcomes and trajectories.

LSAC now has two decades of rich data on child/young person health and physical development; social and emotional wellbeing; cognitive, language, and academic achievement; and economic, vocational, and employment participation. These are underpinned by individual, familial, and contextual data from diverse informants. LSAC is entering an exciting new phase, able to reveal links between children's social and economic contexts in early life and adulthood outcomes.

The study's governance structure is unique, ensuring scientific excellence while maximizing policy influence. The Australian Government Department of Social Services (DSS) commissioned LSAC. The DSS leads ongoing, extensive cross-government, and multisectoral consultation processes to ensure that study content reflects and informs current policy priorities across diverse portfolios. The Australian Institute of Family Studies (AIFS) is responsible for managing project coordination, the fieldwork provider, survey design, data management, and data documentation. The multidisciplinary LSAC Scientific Advisory Group (see 'Acknowledgements') comprises researchers from diverse disciplinary backgrounds, who played a major role in advocating for the study and its initial design, and who continue to provide ongoing advice. The fieldwork provider was the Australian Bureau of Statistics (ABS) for Waves 2 to 9C2, with commercial data-collection agencies employed for Wave 1 and from Wave 10 onwards.

Table 1. Overall design of the LSAC Baby (B) and Kindergarten (K) cohorts.

Wave	1	2	3	4	5	6	7	8	9C1	9C2	10
Year	2004	2006	2008	2010	2012	2014	2016	2018	2020	2021	2023
Baby (B) cohort											
Age (years)	0–1	2–3	4–5	6–7	8–9	10–11	12–13	14–15	16–17	17–18	20–21
N	5107	4606	4386	4242	4085	3764	3381	3127	2017	2688	2498
Response rate (%) ^a	100	90	86	83	80	74	66	61	39	53	49
Kindergarten (K) cohort											
Age (years)	4–5	6–7	8–9	10–11	12–13	14–15	16–17	18–19	20–21	21–22	23–24
N	4983	4464	4331	4169	3956	3537	3089	3037	1789	2463	2335
Response rate (%) ^a	100	90	87	84	79	71	62	61	36	49	47

^a Response rate calculated according to participation at a family-unit level (i.e. at least one parent or study child participated) with further details in [Supplementary Table 1](#). C=COVID-19-focused wave.

Who is in the cohort?

To rapidly deliver insights into major policy questions at the time, LSAC employed an accelerated cross-sequential design (see [Table 1](#)). Recruitment of two nationally representative cohorts was undertaken in 2004 (Wave 1) comprising the Baby (B) cohort aged 0–1 years and the Kindergarten (K) cohort aged 4–5 years. LSAC sampling was designed to be representative of Australian children in 2004, with the B cohort representing infants born from March 2003 to February 2004, and the K cohort representing 4-year-olds born from March 1999 to February 2000. An exception is that LSAC was not intended to be representative of children living in very remote areas, given the pragmatic consideration of face-to-face data collection across the vast Australian continent (7 617 930 km²).

Potential participants were identified from the Australian Government's universal health insurance (Medicare) database and selected in a two-stage stratified, clustered design involving the selection of postcodes and then children within postcodes [4]. Final recruited samples were 5107 at 0–1 years (55% of those selected) and 4983 4-year-olds (49% of those selected). Reasons for non-enrolment were refusals (32% for B cohort, 35% for K cohort), non-contacts (10% and 14%, respectively), and exclusions for broad name matches to the National Death Index (3% each cohort). At Wave 1 (2004), participants in both cohorts were similar to the target Australian populations across a range of child and family characteristics ([Table 2](#) shown for Parent 1 only), although slightly less representative of single-parent families, families with a main language other than English, and where Parent 1 had incomplete high-school education.

How often have they been followed up?

Data have been collected every 2 years, resulting in 10 main waves of data collection by 2024. An exception occurred during the COVID-19 pandemic, where Wave 9 was conducted as two rapid COVID-19 (C) online data collections: (i) October to December 2020 (Wave 9C1) and (ii) June to September 2021 (Wave 9C2). The most recent data collection, Wave 10, was conducted in 2023 and returns to the usual 2-year cycle.

Over 10 waves, non-response has been gradual and intermittent ([Table 1](#) and [Supplementary Table S1](#)). As was common for cohorts internationally, pandemic Waves 9C1 and 9C2 attracted a lower response rate than usual, persisting into Wave 10 ([Table 1](#)). Nevertheless, comparison of the initial recruited samples with the Wave 10 sample shows that those currently engaged continue to reflect a wide range of

Table 2. Wave 1 socio-demographic characteristics (unweighted raw data) of LSAC participants (Parent 1 only)^a for the (i) original recruited samples and (ii) retained samples by Wave 10, as well as census data showing Australian population profile.

Socio-demographic characteristics at Wave 1	B cohort (N, %)		Census 2001 for families with infant (%)	K cohort (N, %)		Census 2001 for families with child aged 4 years (%)
	Recruited sample at Wave 1	Retained sample at Wave 10		Recruited sample at Wave 1	Retained sample at Wave 10	
Sex of Parent 1^a						
Male	74 (1.4)	39 (1.6)	NA	144 (2.9)	64 (2.7)	NA
Female	5033 (98.6)	2459 (98.4)	NA	4839 (97.1)	2271 (97.3)	NA
Sex of study child						
Male	2608 (51.1)	1250 (50.0)	51.3	2536 (50.9)	1152 (49.3)	51.3
Female	2499 (48.9)	1248 (50.0)	48.7	2447 (49.1)	1183 (50.7)	48.7
Household structure						
Two resident parents	4630 (90.7)	2364 (94.6)	88.2	4286 (86.0)	2114 (90.5)	82.1
One resident parent	477 (9.3)	134 (5.4)	11.8	697 (14.0)	221 (9.5)	17.9
Siblings						
Only child	2019 (39.5)	1044 (41.8)	36.3	570 (11.4)	222 (9.5)	12.2
One sibling	1876 (36.7)	918 (36.7)	35.8	2413 (48.4)	1214 (52.0)	46.2
Two or more siblings	1212 (23.7)	536 (21.5)	27.9	2000 (40.1)	899 (38.5)	41.6
State/territory of residence						
New South Wales	1615 (31.6)	771 (30.9)	34.8	1573 (31.6)	740 (31.7)	33.7
Victoria	1251 (24.5)	609 (24.4)	24.1	1245 (25.0)	567 (24.3)	23.8
Queensland	1054 (20.6)	508 (20.3)	19.1	988 (19.8)	446 (19.1)	19.7
South Australia	347 (6.8)	171 (6.8)	7.0	339 (6.8)	149 (6.4)	7.2
Western Australia	533 (10.4)	256 (10.2)	9.6	507 (10.2)	235 (10.1)	10.1
Tasmania	113 (2.2)	66 (2.6)	2.3	136 (2.7)	85 (3.6)	2.5
Northern Territory	87 (1.7)	47 (1.9)	1.7	82 (1.6)	42 (1.8)	1.6
Australian Capital Territory	107 (2.1)	70 (2.8)	2.1	113 (2.3)	71 (3.0)	1.3
Geographic remoteness						
Metropolitan area	3191 (62.5)	1582 (63.3)	65.1	3088 (62.0)	1474 (63.1)	61.9
Rural or regional area	1916 (37.5)	916 (36.7)	34.9	1895 (38.0)	861 (36.9)	38.1
Study child's country of birth						
Australia	5088 (99.6)	2489 (99.6)	NA	4772 (95.8)	2243 (96.1)	NA
Other	19 (0.4)	9 (0.4)	NA	211 (4.2)	92 (3.9)	NA
Study child's Indigenous background						
Aboriginal and/or Torres Strait Islander	230 (4.5)	54 (2.2)	4.5	187 (3.8)	43 (1.8)	3.5
Non-Indigenous	4 877 (95.5)	2444 (97.8)	95.5	4794 (96.2)	2290 (98.1)	96.5
Main language spoken at home						
English	4555 (89.2)	2288 (91.6)	86.2	4359 (87.5)	2101 (90.0)	82.4
Other	549 (10.8)	209 (8.4)	16.8	624 (12.5)	234 (10.0)	17.6
Mother's education						
Completed secondary schooling	3410 (66.9)	1881 (75.4)	56.6	2895 (58.6)	1580 (68.0)	48.3
Did not complete secondary schooling	1688 (33.1)	614 (24.6)	43.4	2044 (41.4)	744 (32.0)	51.7
Father's education						
Completed secondary schooling	2660 (58.5)	1488 (63.5)	49.8	2246 (52.7)	1198 (56.9)	54.7
Did not complete secondary schooling	1890 (41.5)	855 (36.5)	50.2	2016 (47.3)	907 (43.1)	45.3
Parents' employment						
Both parents/lone parent employed	2441 (47.9)	1347 (54.0)	NA	2760 (55.5)	1415 (60.7)	NA
One parent employed (in couple family)	2077 (40.8)	998 (40.0)	NA	1631 (32.8)	766 (32.8)	NA
Neither parent employed	578 (11.3)	150 (6.0)	NA	581 (11.7)	152 (6.5)	NA
Combined income pre-tax (per week)						
<\$800	1533 (31.7)	583 (24.4)	NA	1361 (29.2)	493 (22.1)	NA
\$800–1499	1980 (41.0)	1046 (43.7)	NA	1735 (37.2)	813 (36.5)	NA
≥\$1500	1322 (27.3)	764 (31.9)	NA	1567 (33.6)	920 (41.3)	NA
Relative socioeconomic status (percentile)						
>75th	1278 (25.1)	817 (32.7)	NA	1236 (24.9)	782 (33.5)	NA
50th–75th	1275 (25.0)	686 (27.5)	NA	1239 (25.0)	657 (28.1)	NA
25th–50th	1276 (25.1)	603 (24.1)	NA	1238 (24.9)	513 (22.0)	NA
≤25th	1263 (24.8)	389 (15.6)	NA	1252 (25.2)	380 (16.3)	NA

^a Parent 1: Defined as the parent who knows the child best, usually the mother. Similar data are recorded for Parent 2 ($n = 4571$), of whom $n = 4494$ are fathers.

socioeconomic and demographic characteristics (see [Table 2](#) showing Parent 1 characteristics). This is notable given their 20-year tenure with the study. Continual efforts are underway to re-engage those previously lost (see ‘What are the main strengths and weaknesses?’), targeting common reasons for non-response, such as loss of contact or participant refusal or avoidance [5].

What has been measured?

A notable feature of LSAC is the breadth and richness of data collected ([Fig. 1](#)). This aligns with the overarching aim of the study and the broad range of policy-relevant questions addressed [2]. From the beginning, a set of principles have been used to inform the systematic prioritization of constructs and their measures. At a construct level, these are: (i) theoretical alignment with a socioecological model [3] that recognizes individual, parent, family, social, and environmental influences on life-course development across socio-emotional, cognitive, academic, physical, and other domains of functioning [6]; (ii) relevance at a population level; and (iii) importance to policy [7]. To indicate priority constructs, measurement selection has been guided by: (i) instrument reliability and validity; (ii) time-efficient data collection; (iii) longitudinal consistency; (iv) acceptability to participants; (v) alignment with other studies; and (vi) data not being available elsewhere [7]. Specific topics have had a greater or lesser focus according to their salience across the lifespan ([Fig. 1](#)). Longitudinal consistency in measures has been prioritized where relevant and feasible.

From Wave 1, the same parent-reported data have been collected from ‘both’ parents, when available. The primary carer (i.e. who knows the most about the child, usually the child’s mother) is ‘Parent 1’ (total B cohort P1 = 5107; of whom $n = 5034$ were mothers). Similar data are available from a second resident parent, ‘Parent 2’ (total P2 = 4571; $n = 4494$ were fathers). Over time, an increasing amount of data has been collected from the study children themselves and, at 18 years of age, they were asked to give explicit consent for their continued enrolment and are now considered the primary informant ([Fig. 1](#)). Data are also collected where relevant from a non-resident ‘parent living elsewhere’ (PLE, from Wave 2 onwards); and from the child’s childcare provider (from infancy to school age); and classroom teacher in school years [5].

A wide range of data-collection approaches have been employed ([Table 3](#)). The cornerstone has been face-to-face

interviews. In Wave 10, for example, young people completed a home visit with a face-to-face interview and a self-completed computer-assisted component capturing more sensitive content. This was complemented by a web-based self-complete questionnaire, typically completed prior to the home visit. LSAC has also collected a range of direct assessments of study child and successfully obtained participant consent for extensive data linkage to national administrative data repositories including health, education, and social security ([Table 3](#)). Two externally funded extension projects have been conducted with B cohort: a between-wave survey (Wave 1.5, 2005) about paid maternity leave and the Child Health CheckPoint [8]—a detailed physical health and biomarker data collection ([Table 3](#)).

What has it found?

LSAC has generated a phenomenally rich and varied body of research across a range of disciplines about crucial lifetime health domains and influences. [Figure 2](#) shows in summary the breadth and relative volume of research conducted across major topic areas in >1600 publications to date (<https://flosse.dss.gov.au/flossejspui/cris/explore/publications>). This reflects the study’s novel content and scope, which, as the cohorts enter adulthood, remain highly generative for new knowledge. For example, data on outcomes of high salience to young adults’ health, wellbeing, and participation, such as education, employment, or family formation, are becoming available in Wave 10 data. We use mental health and obesity below as just two examples of areas with significant research contribution from LSAC, leveraging distinctive features of the data ([Table 3](#)) and furthering the study’s aim of understanding the complex and dynamic experience of major public health challenges [9, 10].

Mental health

The measurement of study children’s mental health using age-appropriate indicators at every wave has allowed exploration of the pathways of mental health challenges and strengths over time [11, 12]. The data have highlighted the implications of mental health for healthcare costs [13, 14] and the effects of early mental health on inflammation and other non-communicable diseases [15]; academic and learning success [16, 17]; wellbeing during the COVID-19 pandemic [18]; and mental health in subsequent developmental periods [11, 12]. LSAC has also contributed extensively to understanding early influences on mental health [19–21],

	Subject	Early years (0-3y)	Early childhood (4-7y)	Mid childhood (8-11y)	Adolescence (12-17y)	Young adulthood (18-25y)
Family demographics	N/A	✓	✓	✓	✓	✓
Housing and home environment	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓
Education	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓
Employment, income and finances	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓
General development and learning	Young person	✓	✓	✓	✓	✓
Physical health	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓
Mental health	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓
Parenting and other relationships	Parent	✓	✓	✓	✓	✓
	Young person	✓	✓	✓	✓	✓

✓	Young person provided
✓	Parent provided
✓	Young person and parent provided

Figure 1. LSAC topics and subject (parent, young person) of data collection, at study child ages, with study child and parent as main respondents.

Table 3. Data-collection modalities across main waves and special initiatives to enhance and extend the LSAC data.^a

Modality	Description
Main waves of data collection	
Interviews and questionnaires	Main waves of data collection are conducted every 2 years (with the exception of COVID-19), paper-based at Wave 1 with increasing use of computer-assisted and online formats across subsequent waves. At each wave, data-collection centres on a face-to-face computer-assisted interview conducted by a trained and skilled interviewer. To manage participant burden and for the collection of sensitive information, this is supplemented with self-complete questionnaires, computer-assisted self-interviews, and computer-assisted telephone interviews
Study informants	In the main waves, depending on age, interview and/or questionnaire data have been collected from: the study child; Parent 1 (P1), defined as the parent who knows the most about the child (not necessarily a biological parent); Parent 2 (P2), if there is one, defined as another person in the household or the partner of Parent 1 (not necessarily a biological parent); PLE, if there is one, defined as a parent who lives apart from Parent 1 but who has contact with the child (not necessarily a biological parent); carers/teachers; and interviewers
Direct assessments	During face-to-face interviews, the interviewer physically measured the child, including height, weight, girth, body fat, and blood pressure (Waves 1–8); directly assessing the child’s vocabulary and cognition by using standardized assessments for three consecutive waves from age 4–5 years. Executive and cognitive functioning was measured, also through standardized direct assessments, when the cohorts were aged 14–15 years (Waves 6 and 8 for K and B cohorts, respectively)
Structured time-use and event-history data	Time-use diary—at Waves 1–3 for both cohorts, light time-use diaries were completed by P1 for a randomly selected weekday and weekend day. These collected 15-minute interval data on children’s activities (e.g. unstructured play, structured activities, self-care, travel), who was with the child, and whether the child was indoors or outdoors. From ages 10–11 to 14–15 years (Waves 4–6 for K cohort; Waves 6–8 for B cohort), child self-reported time-use-diary data were collected for a single day, using an interviewer-assisted computer-based record Event-history calendar collecting employment, residential, and education event histories for the preceding 2 years from the K cohort (Waves 7 and 8). For Wave 10, education event histories were replaced by relationships and were collected for the previous 5 years for the K cohort and previous 2 years for the B cohort
Special initiatives and extensions to the data	
In addition to the main waves, a range of special initiatives and extensions to the data have been periodically undertaken to increase the richness, robustness, and breadth of data available	
Mini-waves	Mini-waves have been conducted intermittently, focusing on specific topics. In 2005 (Wave 1.5 parental leave and employment), 2007 (Wave 2.5 childcare experiences and development), and 2009 (Wave 3.5, schooling, health), parents were also asked to complete a between-waves mail survey. In 2011 (Wave 4.5), the between-wave data collection changed from a paper-based questionnaire to an internet-based form for respondents to report changes in contact details to aid tracking
Direct assessments	The Child Health CheckPoint [8]—a physical biomarker module—was conducted for N = 1800 B Cohort children and parents in 2015–2016, collecting biological samples, physical health assessments, and digital information (e.g. imaging, tracking)
Data linkage	Extensive data linkage has been conducted with government administrative records including: national health service data (SC, P1, P2) with linkage conducted with Australia’s Medicare Benefits Scheme administrative data, which include the Pharmaceutical Benefits Scheme (all prescription medicines) and the Australian Childhood Immunisation Register; social welfare including income, family, and disability support (SC, P1, P2); educational linkage (SC) including the Australian Early Development Census-linked national school readiness data from the first year of school in 2009 (B cohort only), National Assessment Program Literacy and Numeracy (NAPLAN, linked at Grades 3, 5, 7, and 9), MySchool data, which provide school-level data on school performance in NAPLAN, and school demographics and financial information. Additional geospatial data (SC main residence) has also been linked, such as socioeconomic status of the area (SEIFA), remoteness from major service centres, and distance to the coast (Waves 1–10)

^a Further details of specific measurements are available at <https://aifs.gov.au/growing-australia/data-users/documentation>.

including recognizing the mental health of ‘mothers and fathers’ as a major resource for families, affected by parent and family socioeconomic circumstances and adversity [21, 22]; and parents’ job quality [23, 24]. Contemporary Australian policy on men’s mental health has been informed by a series of LSAC studies on mental health in fathers [25, 26].

Obesity

Directly measured and self-reported physical health data have been used to understand obesity pathways. This includes demonstrating socioeconomic inequalities in body mass index (BMI) trajectories [27, 28]; the early-life predictors of weight [29, 30]; and the role of parental perceptions of children’s weight [31]. Novel time-use diary data have

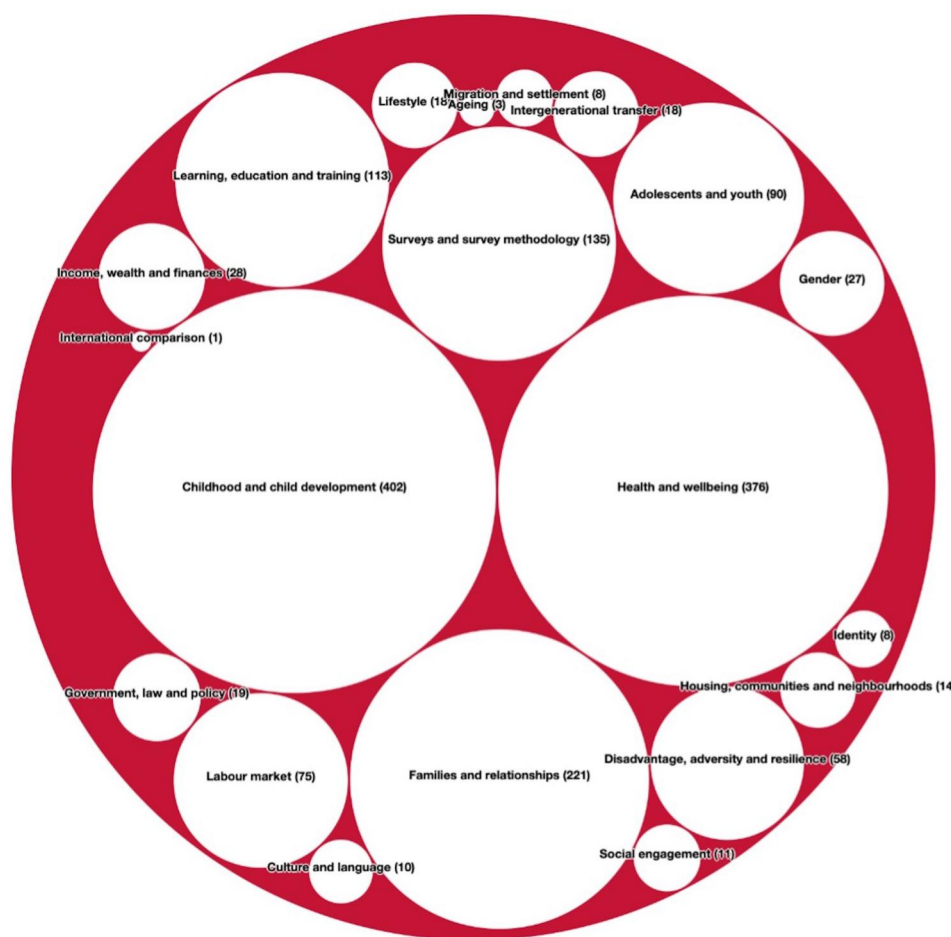


Figure 2. Number of publications using data from LSAC, summarized in major topic areas. **Caption:** Reprinted with permission from Australian Government Department of Social Services (<https://flosse.dss.gov.au/flossejspui/surveysubject.jsp?project=LSAC>).

shown how maternal work shapes lifestyle behaviours and weight [32]. Additionally, biosamples from the subgroup of children who participated in the Child Health CheckPoint were used to develop polygenic risk scores for BMI and then explore non-nutritive (i.e. artificially sweetened) beverage consumption [33], while, more recently, the interactive impact of BMI polygenic risk with socioeconomic disadvantage has been shown [34]. Causal mediation analysis has been used to elucidate the impact of adverse childhood experiences on children's BMI [35].

What are the main strengths and weaknesses?

LSAC provides a rich, intergenerational view of children's health and wellbeing, tracking participants from infancy to young adulthood. The study offers wide-ranging data on the young persons' health and wellbeing over multiple domains, and is one of the first national cohort studies to collect comprehensive self-report and linked data on both mothers and fathers, including parents who no longer reside full-time with the child. As the study children reach adulthood and potentially become parents themselves, LSAC data can connect four generations, including grandparents, parents, original study children, and their offspring [36]. Government-led collaboration with policymakers across an array of portfolios ensures that the study remains attuned and responsive to evolving policy, social, and economic climates. Additionally,

with a sample that is population-representative of Australia's eight state/territory jurisdictions, policy evaluations can be undertaken for state-level initiatives [37]. The multidisciplinary Scientific Advisory Committee ensures scientific rigour across specialist domains and has fostered alignment and harmonization with other leading international cohort studies, increasing utilization [18, 35, 38]. The rigour of the data is also underpinned by modest attrition; representativeness of the retained sample compared with baseline; use of diverse data-acquisition approaches; multiple-informant perspectives; and a successful transition, whereby the original study children are now primary informants for data collection. These strengths position LSAC to generate robust, timely, and impactful evidence on pre-existing, emerging, and evolving risk and protective factors relevant for young Australians, informing both longstanding (e.g. mental ill-health, obesity) as well as rapidly emerging (e.g. COVID-19, vaping, social media) public health and societal challenges.

LSAC limitations include a recruited sample that was slightly less representative of disadvantaged groups (Table 2). The breadth of content meant necessary compromise in the depth of measurement for some constructs to manage respondent burden. As with most cohort studies, attrition is somewhat greater amongst more socially disadvantaged participants (e.g. those in the lowest socioeconomic quartile). Nevertheless, the study continues to capture participants from a wide range of

socioeconomic and demographic circumstances, and generate important work relating to adversity and equity [39–43].

In Waves 9C1 and 9C2 (2020 and 2021), COVID-19 was a particular challenge to response rates with data collected online and via telephone. Previously, the connection established through face-to-face data collections was regarded as central to maintaining participant engagement. The anticipated rebound in response rates with the resumption of face-to-face interviews at Wave 10 has not eventuated. This may be partly due to a concomitant change in fieldwork providers, potentially affecting participant trust and engagement. In addition, Waves 9C–10 were a transition period for the young people, renegotiating their participation as primary respondents themselves. A range of active strategies to reinvigorate the cohort are underway, including attempts to reconnect with those lost to follow-up in earlier waves. We are optimistic about the future of the cohort now that it is at the point at which the study child is an adult and the value of comprehensive early-life data for understanding adult outcomes are realized.

Can I get hold of the data? Where can I find out more?

From the outset, LSAC was established with a genuine commitment to open science practice, not just making data accessible, but also providing comprehensive, publicly available description and guidance on use of the data (<https://growingupinaustralia.gov.au/data-and-documentation>). This includes technical reports on specialized areas such as data linkage and extensive information about data-collection tools, including a comprehensive (web-based or Excel) data dictionary with detailed, searchable information on topics and constructs. This allows the data to be used to maximum advantage, as seen by the >1351 registered data users to date, and it has served as an exemplar of open science practice for many other cohorts in the region [44]. Data can be accessed through a simple and streamlined application process; access to data by researchers outside of Australia is welcome and may entail a slightly longer processing time ([https://dataverse.ada.edu.au/dataverse.xhtml? alias=lsac](https://dataverse.ada.edu.au/dataverse.xhtml?alias=lsac)).

Ethical approval

Ethical approval was granted by the AIFS Human Research Ethics Committee.

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Author contributions

A.R.C., M.O., and J.M.N. were responsible for primary drafting, oversight, and management. D.B., J.M.N., A.V.S., and S.R.Z. were responsible for substantial contributions to the design, acquisition, and analyses of the data. P.H., A.F., B.E., M.O., and T.S. were responsible for preparation of data and tables. L.S. and J.M. were responsible for the 'What has been measured' and 'What has been found' sections. All authors critically reviewed the manuscript for important intellectual content, approved the final draft for submission, and are accountable for the accuracy and integrity of the work presented here.

Supplementary data

[Supplementary data](#) is available at *IJE* online.

Conflict of interest

The authors declare that there are no conflicts of interest.

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Data availability

The data underlying this article is accessible via an application process made to the following (<https://dataverse.ada.edu.au/dataverse.xhtml?alias=lsac>). Application process requires a brief project description, listing of co-investigators, and completion of a Deed of Confidentiality.

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Cohort Profile