Frequently Asked Questions

Childhood adversity, overdose, and suicide are urgent and related public health challenges that have consequences for all of us. But these challenges are preventable if we adopt a coordinated approach that focuses on addressing today's crises while preventing tomorrow's.

What are Adverse Childhood Experiences (ACEs)?

Adverse childhood experiences (ACEs) refers to all types of potentially traumatic events and experiences that occur to people under the age of 18. ACEs include exposure to abuse, neglect, parental substance use, parental divorce, violence, etc.[1]

How common are ACEs?

Childhood trauma touches half of all US children, in every community. One third of the children in the U.S. and 61% of adults) have experienced at least one adverse childhood experience;[2] 25% of adults had experienced three or more and more than 14% of children have experienced two or more. Five of the 10 leading causes of death are related to exposure to adverse childhood experiences.[3]

Why are ACEs a cause for concern?

Experiencing adversity in childhood can change the way a child's brain develops and functions, contributing to increased risk of substance use, suicide and other injury and violence outcomes. ACEs can shorten a person's life span by as much as 19 years. The estimated US population economic burden of ACEs is billions of dollars each year. The annual lifetime cost of child abuse and neglect, one type of ACE, alone was $428 billion in 2015.[4]

How common is overdose in the United States?

From 1999 to 2018, more than 750,000 people in the United States died from a drug overdose.[5] The number of drug overdose deaths was four times higher in 2018 than in 1999.[5] Provisional estimates also indicate an 8% increase in overdose deaths from 2019 to 2020.[6] In 2018 alone, more than 67,000 people died from drug overdoses, making it a leading cause of injury-related death in the United States.[7] Two out of three of those deaths involved a prescription or illicit opioid.[5] In fact, on average, 128 Americans die every day from an opioid overdose every day.[5]

How common is suicide in the United States?

Suicide is the 10th leading cause of death in the United States.[8] It is the second leading cause of death for people 10 to 34 years of age, the fourth leading cause among people 35 to 54 years of age, and the eighth leading cause among people 55 to 64 years of age.[2] Suicide was responsible for more than 48,000 deaths in 2018, resulting in about one death every 11 minutes.[2] Every year, many more people think about or attempt suicide than die by suicide. In 2019, 12 million American adults seriously thought about suicide, 3.5 million made a plan, and 1.4 million attempted suicide.[9] Between 1999-2018, suicide rates have risen 35 percent.[10]

Aside from the impact on the individual and family, are there any other consequences of suicide?

In addition to the number of people who are injured by suicide attempts or die by suicide, many more people are impacted. When people die by suicide, friends and loved ones may experience shock, anger, guilt, and depression, among other feelings. In fact, people who survive the loss of someone they know to suicide are at increased risk themselves of this same outcome.[8] People who attempt suicide and survive may experience serious injuries and negative impacts (such as feelings of shame and guilt), which can have long-term effects on health and well-being.[11] The good news is that most people who attempt suicide go on to live long and healthy lives.[12] In addition to the physical and emotional toll of suicide and suicide attempts, the economic toll is immense as well with suicides and suicide attempts costing the nation approximately $70 billion per year in lifetime medical and work-loss costs alone.[2]

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Is anyone at greater risk of suicide?

Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native and non-Hispanic White populations.[11] Other Americans disproportionately impacted by suicide include Veterans and other military personnel and workers in certain occupational groups like construction and the arts, design, entertainment, sports, and media fields.[8, 13] Sexual minority youth bear a large burden as well, and experience increased suicidal ideation and behavior compared to their non-sexual minority peers.[8]

How are these three issues connected?

These challenges are related because adverse childhood experiences increase the risk of overdose and suicide later in life. And since witnessing an overdose or losing a loved one to suicide are adverse childhood experiences, the risk of future overdose or suicide grows and the problem ripples and multiplies across generations. Preventing exposure to adverse childhood experiences is an important step in reducing the risk for overdose and suicide, and many other negative health and wellbeing outcomes.

What can we do to more effectively prevent ACEs, overdose, and suicide?

1. Generate understanding of the shared root causes between ACEs, overdose, and suicide to inform more holistic and effective policy, programmatic interventions, funding, and service delivery. We can advance this understanding by using shared, evidence-based, and easy-to-understand messages that make the connection and capture the urgency needed to find innovative solutions.
2. Engage with individuals as leaders for prevention and change in their own communities, including those with personal experience with these issues, decision-makers, and champions across sectors.
3. Employ a comprehensive public health approach to:
    - prevent harm from occurring in the first place,
    - identify people in need of services early and ensure equitable access to the programs and services they need,
    - provide long-term social and economic supports (e.g., income support for working families, paid family and sick leave, high quality childcare, and access to substance use treatment that increase safe, stable, nurturing relationships and environments).

    Efforts may be most effective if we begin by focusing policies, funding and programs where the need is greatest
4. Invest in research and evaluation to develop, test, implement, and translate more evidence-based strategies to prevent and mitigate the effects of adverse childhood experiences, overdose and suicide, and to address the connections between them.

---

1 https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html

2 https://mchb.hrsa.gov/sites/default/files/mchb/Data/NSCH/nsch-data-brief.pdf

3 https://www.cdc.gov/vitalsigns/aces/index.html

4 CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). (2020) Atlanta, GA: National Center for Injury Prevention and Control. https://www.cdc.gov/injury/wisqars/index.html.

5 https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

6 https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

7 https://www.cdc.gov/injury/wisqars/LeadingCauses_images.html

8 CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). (2020) Atlanta, GA: National Center for Injury Prevention and Control. https://www.cdc.gov/injury/wisqars/index.htm.

9 Substance Abuse and Mental Health Services Administration. (2019) Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/

10 https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf

11 Stone DM, Holland KM, Bartholow B, Crosby AE, Davis S, Wilkins N. (2017) Preventing suicide: A technical package of policies, programs, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

12 Owens D, Horrocks J, and House A. Fatal and non-fatal repetition of self-harm: systematic review. British Journal of Psychiatry. 2002;181:193-199.

13 Peterson C, Stone DM, Marsh SM, et al. Suicide Rates by Major Occupational Group — 17 States, 2012 and 2015. MMWR Morb Mortal Wkly Rep 2018;67:1253–1260. DOI: http://dx.doi.org/10.15585/mmwr.mm6745a1