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An Investigation of Problem Gambling and Young Sports Players in an Irish Amateur Sporting Organisation.

Maurice Murphy

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Maurice Murphy[1]

E: Maurice.murphy@cit.ie

School of Business, Cork Institute of Technology, Cork, Ireland

T: +353 21 433 5626

ABSTRACT

The gambling industry is huge in Ireland. The betting firm Paddy Power alone had an operating profit of €163.8million in 2014. The activity has become more popular and accessible in recent years due to its move online. In fact, anybody with a smartphone can gamble wherever they may be. While research within Ireland has been limited, there are some startling statistics related to gambling addiction in Ireland with roughly 7% of gamblers at risk of developing a gambling problem and approximately 30-35% of the gambling industry's revenues coming from those who have gambling issues. According to the Institute of Public Health in Ireland, gambling addiction affects young people at 2-3 times the rate of adults. This research aims to investigate the extent of gambling and problem gambling in an amateur sporting organisation (Gaelic Athletic Association – GAA) in Ireland using the Health Belief Model.

KEY WORDS

Problem gambling; sporting organisations; social marketing; Health Belief Model

[1] Senior Lecturer, Cork Institute of Technology, Cork, Ireland.

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1. Introduction

Gambling is an activity which may be summarised as involving participation in games of chance for money (Fulton, 2015). Gambling is an activity that has a long history (Downs, 2010), and is a prominent feature of most cultures (McMillen, 1996). If viewed as a consumer product, gambling has one of the highest penetrations in populations where the product is legal. Gambling is also one of the most frequently purchased products among consumers (Mizerski, *et al.*, 2004). Approximately 80% of the US, 68% of the British, 71% of Canadians and 80% of the Australian 18+ population gambled in the past year (Gambling Commission, 2007).

With gambling available in varied venues, ranging from the internet to casinos, game machines in pubs, and scratch cards in shops, opportunities to gamble are many (Fulton, 2015). Gambling is rapidly emerging as an important global public health issue, with gambling products causing considerable health and social harms for individuals, their families, and the broader community (Thomas and Thomas, 2015). Estimates of the numbers of individuals for whom gambling becomes a problem vary. It is generally considered that while many may take part in gambling as a pastime, a relatively small cohort may find that participation in gambling leads to addiction (Fulton, 2015).

Problem gambling can lead to complete social breakdown, with devastating financial losses, property losses, and alienation of family and friends (Fulton, 2015). Often problem gambling is a behaviour conducted in secret, becoming known to the gambler's social network only when negative financial and social difficulties arise. With the addition of casino, mobile phone and Internet gambling to the more traditional forms of gambling (e.g., lotteries, scratch card tickets, horse and dog racing, bookmakers' shops, etc.), gambling opportunities, both publicly and covertly, can be easily accessed (Fulton, 2015).

The Rutland Treatment Centre in Ireland (www.rutlandcentre.ie) states that while research within Ireland has been limited, there are some startling statistics related to gambling addiction in Ireland:

- Roughly 7% of gamblers are at risk of developing a gambling problem (Freyne, 2015).
- Roughly less than 1% of gamblers have a gambling addiction - however, approximately 30-35% of the gambling industry's revenues comes from those who have gambling issues (Freyne, 2015).
- Gambling is moving online, making it harder to track the behavioural activity of a loved one. In 2008, there were 1,365 betting shops in Ireland, which reduced to 948 in 2015. Paddy Power says that 77% of its profits comes from the online side of the industry (www.rutlandcentre.ie)
- According to the Institute of Public Health in Ireland, gambling addiction affects young people at 2-3 times the rate of adults (Institute of Public Health, 2010).
- Over €5bn each year is gambled in Ireland - that's €10,000 every minute (www.rutlandcentre.ie).

Researchers argue that the harms associated with gambling are on a par with the harms associated with major depressive disorder, and substance use and dependence (Browne *et al.*, 2016), and have spoken about numerous links between harmful gambling and a range of health and social issues (Williams *et al.*, 2012; Suomi *et al.*, 2013). While it is difficult to determine causal direction, research has demonstrated that problem gamblers experience significant comorbidities relating to other mental health problems (Cook *et al.*, 2015) and dependence on other substances (Cowlishaw *et al.*, 2014). Debates around the legalisation and regulation of gambling typically include consideration of the propensity for harm (Reith, 2011).

Research suggests that increased availability and accessibility to gambling opportunities is related to increased levels of problems, although the impact is moderated by other factors (Reith, 2012). Technological advances, wide usage of new devices, and innovation led by the gambling industry has led to a plethora of new internet gambling products available constantly via mobile and other non-computer devices. This has led to the situation where regulators attempt to devise policies that take into account forms of gambling that may not yet be developed (Orford, 2005).

Much of the research in the gambling field has considered gamblers as a homogeneous population or has studied a single gambling activity in isolation (Gainsbury *et al.,* 2015). These studies fail to reflect the heterogeneous nature of gambling and to account for subtypes of gamblers based on how they engage with gambling in various ways (Nower *et al.,* 2013). Research also shows that some population subgroups, including older adults, young men and children, are more vulnerable to developing harm with a range of different gambling products (Pitt *et al.*, 2016).

International research studies have suggested that single men under the age of thirty-five are at greatest risk of problem gambling (Analytical Services Unit DSD, 2010; Wardle *et al.*, 2011). It has been estimated that between 28,000 and 40,000 people in Ireland suffer from a gambling disorder (The Irish Institute of Public Health, 2010) and that adolescent gambling is two to three times greater than for adults, in particular as a consequence of online gambling (The Irish Institute of Public Health, 2010). The UK Prevalence Studies (Wardle *et al.,* 2011) and Forrest and McHale (2012) have reported that adolescent gambling is up to two to four times greater than for adults.

Research also shows that some population subgroups, including older adults, young men, and children, are more vulnerable to developing harm with a range of different gambling products (Kerber *et al.*, 2008). Problem gambling can lead to complete social breakdown, with devastating financial losses, property losses, and alienation of family and friends. Often problem gambling is a behaviour conducted in secret, becoming known to the gambler's social network only when negative financial and social difficulties arise. With the addition of casino, mobile phone and Internet gambling to the more traditional forms of gambling (e.g., lotteries, scratch card tickets, horse and dog racing, bookmakers' shops, etc.), gambling opportunities, both publicly and covertly, can be easily accessed (Fulton, 2015).

2. Gambling and Sports People

Gambling and problem gambling, a condition associated with financial consequences and severe mental health complications (Ronzitti *et al.,* 2018), may intuitively have an association with a typical competitive mind-set that is fostered and seen as a normal and desirable part of sports. This potential link between sports and gambling has frequently been reported in the popular media detailing sports stars and their addictive gambling, such as the Swedish multiple Olympic and world champion medallist in table tennis, Jan-Owe Waldner (Moldovan, 2011). Altogether, several factors suggest that the context of competitive sports may be a potential risk factor for problem gambling.

More recently, there has been an increasing involvement of gambling marketing in sports (Lopez-Gonzalez and Griffiths, 2018); gambling operators have been reported to represent some of the most common sponsorships in national and club level sports (Maher *et al.,* 2006), and this includes the involvement of well-known athletes in gambling-related marketing. Also, the age span of elite level athletes (i.e., the years they compete at national or international level) typically corresponds well to the

age where problem gambling has been found to be the most pronounced (Allen and Hopkins, 2015), and personality traits of competitiveness have been suggested to be a risk factor of problem gambling (Harris *et al.*, 2015).

However, despite this potential link between sports and gambling, studies in the area have been few. Stillman and co-workers reported that problem gambling may be more prevalent in athletes than in the general population (Stillman *et al.*, 2016), and higher in male athletes than in their female counterparts (Huang *et al.*, 2010). Grall-Bronnec and colleagues reported 8.2% of lifetime prevalence of problem gambling in European professional athletes in a number of team sports (Grall-Bronnec *et al.*, 2016), and this can be compared to the prevalence of problem gambling in the general population, reported to be between 0.7 and 6.5% world-wide, although definitions and instruments have varied across studies (Calado and Griffiths, 2016). However, no research has studied whether problem gambling differs between team sports and individual sports, a relevant research question based on the large involvement of gambling marketing in particularly team sports (Maher *et al.*, 2006).

3. Amateur Sport in Ireland

The Gaelic Athletic Association (GAA) is an Irish international amateur sporting and cultural organisation, focused primarily on promoting indigenous Gaelic games and pastimes, which include the traditional Irish sports of hurling, camogie, Gaelic football, Gaelic handball and rounders. The Gaelic Players Association represents the interests of all GAA players. According to the Gaelic Players Association (GPA) of the GAA, Irish people are estimated to gamble over €5 billion per year; that's €14 million per day or €10,000 per minute (GPA, 2018). In 2017, gambling addiction made up 33% of the cases that presented to the GPA counselling service for treatment (GPA, 2018).

The new code of conduct on gambling enacted by the GAA in 2018 has been funded by the European Commission and developed in partnership with EU Athletes (of which the GPA is a member), the European Gaming and Betting Association, the Remote Gambling Association and the European Sports Security Association. It compliments any rules provided by national laws, international conventions and sport regulations, both national and international. The new code of conduct is designed and tailored to give specific advice for GAA county players.

4. Research Question and Research Objectives

The research question for this research is:

- Is there a problem with gambling in GAA amateur sports in Ireland?

The research objectives are:

- Are amateur sports people more prone to problem gambling?
- Why are amateur sports people more prone to problem gambling?
- What can be done to prevent amateur sports people becoming problem gamblers?

The aim is to conduct this research using 8 focus groups and 10 semi-structured interviews with GAA players in Cork Institute of Technology, Cork, Ireland as well as conducting semi-structured interviews with leading members of the GAA, GPA and addiction counsellors to ascertain the extent of problem gambling among young players in this sporting organisation and what can be done to tackle this issue.

5. Methodology

A model derived from the fields of health psychology and health education that adds to the understanding of the motivation to quit or cut-back is that of the Health Belief Model (HBM). This model suggests six factors that influence the probability that a person with an addictive disorder will quit of cut back (Becker, 1974). There are six beliefs central to this theory. This research will test the Health Belief Model that attempts to explain the conditions that are necessary for behaviour change to occur. The model states that an individual will take action to prevent, screen for, or control a disease or condition based on the following factors:

- Perceived susceptibility – the individual must believe that he or she is susceptible to the condition.
- Perceived severity – the individual must believe that getting the disease or condition leads to severe consequences.
- Perceived benefits – the individual must believe that engaging in the preventive behaviour will reduce the threat or provide other positive consequences.
- Perceived barriers – the individual must believe that the tangible or psychological costs of performing the behaviour are of less magnitude than its benefits.
- Cues to action – the individual must encounter something that triggers readiness to perform the behaviour.
- Self-efficacy – the individual must believe he or she can take action.

(Strecher and Rosenstock, 1997, pp 41-59)

Perceived susceptibility may be understood as a person's subjective understanding of their vulnerability to engaging in a health destructive behaviour, and to the consequences of engaging in that behaviour (Stroebe and Stroebe, 1996). In the context of the current study, this would be an

individual's beliefs about their ability to become a problem gambler. Those who believe that they have a high level of control over their betting behaviour will not see themselves as susceptible to the consequences of problematic gambling. However, those who recognise that they have impaired control over how much they gamble will see themselves as more susceptible to engaging in excessive gambling according to this model. They will also associate negative life consequences associated with this health destructive behaviour. Following from the HBM's predictions, this perception will influence the level of motivation to resolve their problematic behaviour.

The second factor which influences motivation to change is perceived severity. This factor may be understood as the subjective understanding of the seriousness of the consequences of engaging in a health destructive behaviour (Armitage and Conner, 2000). Therefore, in the context of this study, when an individual believes that continuing to gamble will make them highly likely to experience serious negative consequences, such as loss of one's job, they will be more likely to become more motivated to resolve their gambling problem.

Health-related behaviours are also influenced by the perceived benefits of taking action (Glanz, *et al.,* 2008). Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease (Janz and Becker, 1984). If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness (in this case, problem gambling), then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action (Rosenstock, 1984). For example, individuals who believe that disengaging from problem gambling will result in benefits (financial and otherwise) are more than likely to stop gambling.

Health-related behaviours are also a function of perceived barriers to taking action (Glanz, *et al.,* 2008). Perceived barriers refer to an individual's assessment of the obstacles to behaviour change (Janz and Becker, 1984). Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers for behaviour change to occur (Glanz, *et al.,* 2008; Janz and Becker, 1984). Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the new behaviour (Rosenstock, 1974). For instance, lack of access to addiction services and the issue of the addiction itself may act as barriers to changing problem gambling behaviour.

The health belief model argues that a cue, trigger or stimulus, is necessary for prompting engagement in health-promoting behaviours (Rosenstock, 1974). Cues to action can be internal or external (Janz and Becker, 1984). Physiological cues (e.g., pain, symptoms) are an example of internal cues to action

(Glanz *et al.,* 2008). External cues include events or information from close others (Janz and Becker, 1984), the media (Carpenter, 2010), or health care providers (Janz and Becker, 1984) promoting engagement in health-related behaviours. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers (Rosenstock, 1974). For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.

Self-efficacy was added to the four components of the health belief model (i.e., perceived susceptibility, severity, benefits, and barriers) in 1988 (Glanz *et al.,* 2008). Self-efficacy refers to an individual's perception of his or her competence to successfully perform a new behaviour (Glanz *et al.,* 2008). Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviours (Rosenstock *et al.,* 1988). The model was originally developed in order to explain engagement in one-time health-related behaviours such as being screened for cancer or receiving an immunization (Rosenstock *et al.,* 1988). Eventually, the health belief model was applied to more substantial, long-term behaviour change such as diet modification, exercise, and smoking (Rosenstock *et al.,* 1988). Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy) was a key component of health behaviour change (Glanz *et al.,* 2008).

The aim is to conduct this research using focus groups and semi-structured interviews with GAA players in Cork Institute of Technology, Cork, Ireland as well as conducting semi-structured interviews with leading members of the GAA, GPA and addiction counsellors to ascertain the extent of problem gambling among young players in this sporting organisation and what can be done to tackle this issue.

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