To Zoom or Not to Zoom? Comparing In-Person and Virtual Trainings in the ACT Raising Safe Kids Program

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Abstract

The COVID-19 pandemic forced child welfare providers to shift to virtual training platforms, raising questions about the quality of virtual versus in-person instruction. This study evaluated whether there are significant differences in quality between virtual and in-person formats of the ACT Raising Safe Kids Facilitator Training, which prepares professionals to deliver evidence-based, childhood violence prevention parenting programming. Archival data were examined from two virtual and three in-person training sessions between 2019-2022. Independent samples *t*-tests revealed no significant differences between groups in terms of preparedness, satisfaction, and implementation likelihood. However, virtual participants reported significantly greater audiovisual material satisfaction and trended toward greater preparedness to work with diverse populations. Findings suggest that virtual training can be as effective as in-person delivery.

Keywords: *virtual training, child abuse prevention, professional development, online learning.*

Since the onset of the COVID-19 pandemic, there has been a significant increase in the utilization of virtual services (CDC, 2024; Pruiksma et al., 2022). However, this transition has been accompanied by notable challenges, particularly in the delivery of programs supporting families and children. Traditional early intervention and child maltreatment prevention training programs have faced difficulties in their virtual implementations (Katz, 2021). These challenges are particularly concerning given the global increase in child maltreatment cases (WHO, 2020; Bullinger et al., 2023; Lee et al., 2022), including instances of physical and emotional neglect, coupled with a troubling decrease in international reporting to child protection services (Marmor et al., 2023). The swift adaptation of prevention intervention from in-person to virtual training formats during the pandemic prompts questions regarding the precise impact, quality, and effectiveness of this transition. The current study aimed to assess whether training facilitators on the American Psychological Association's (APA) ACT Raising Safe Kids (ACT RSK) Program can be effectively delivered in a virtual format compared to its traditional in-person modality.

The ACT Raising Safe Kids (ACT RSK) Program

The ACT RSK program is a comprehensive, evidence-based, parenting program that focuses on enhancing positive parenting practices and preventing child maltreatment (APA, 2017a; APA, 2017b; APA, 2017c; California Evidence-Based Clearinghouse for Child Welfare, 2022; Pontes et al., 2019). Taking a public health approach, the program aims to educate and mobilize families, professionals, and communities proactively to prevent violence. The program is manualized, psychoeducational, evidence-based, and designed to promote positive parenting as well as prevent violence. It enhances parents' knowledge, skills, and supportive relationships (APA, 2017c). It has demonstrated promising outcomes across three evaluation studies (Knox et al., 2013; Portwood et al., 2011; Thomas et al., 2009), two of which employed rigorous randomized controlled trial (RCT) designs (Portwood et al., 2011; Thomas et al., 2009).

This intervention with parents is delivered in nine group-based sessions, each lasting approximately two hours, and is facilitated by trained professionals using a structured curriculum. Program content is organized around three core domains: (a) knowledge and beliefs about child development, (b) the importance of healthy, nurturing relationships, and (c) the development of evidence-based, positive parenting skills (APA, 2017c). Sessions combine interpersonal interaction with accessible educational materials to promote understanding of children's behavior, emotion regulation, discipline strategies, media use, and nonviolent conflict management (APA, 2017c). Materials are written at a sixth-grade reading level, translated and culturally adapted for diverse populations, and implemented using a strength-based, nonjudgmental approach. Through this structured yet flexible delivery model, the ACT RSK program functions as a primary prevention intervention by reducing psychological and physical aggression, improving parental coping and social support, and preventing the escalation of behavioral and conduct problems in children (APA, 2017c).

The ACT RSK Facilitator Training

Many professionals and paraprofessionals who serve families are eligible to be trained to deliver the ACT RSK program to parents (APA, 2017a). This includes professionals in early education, psychology, counseling, social work, healthcare, and community development. The two-day training, conducted by certified master trainers, offers experiential learning through presentations, large and small-group discussions, role-playing, and practical activities. Participants who complete the facilitator training can pursue certification by conducting an ACT RSK intervention group with parents and caregivers; maintaining a weekly checklist, attesting to covering all the content with fidelity; audio or video recording session six, which covers parenting styles and discipline; and having a follow-up session with a Master Trainer to review the checklist and recording as well as finalize the certification process.

Advantages and Benefits of Virtual Training

Though several ACT RSK Master Trainers moved their training online during the pandemic out of necessity, research has shown that virtual training has certain advantages and benefits. Previous research from Pruiksma et al. (2022) highlights the potential advantages of virtual training for treatment providers compared to in-person training. Virtual training provides many benefits over in-person sessions, such as the elimination of geographical barriers, reduced travel time and cost, greater accessibility, and flexible scheduling (Armistead et al., 2013).

Challenges of Virtual Delivery

Despite the benefits, virtual program delivery presents notable challenges. Technical difficulties, such as unreliable internet access or unfamiliarity with digital platforms, can disrupt participation and impede learning. Maintaining engagement in an online format can be difficult, particularly for participants with lower initial motivation, which may contribute to higher attrition rates, defined as participants discontinuing training or failing to complete post-training assessments (Sitzmann et

al., 2010). Reduced opportunities for interpersonal interaction may also limit the relational and peer-support components that enhance training effectiveness. Additionally, adapting materials and delivery to meet the needs of culturally and linguistically diverse participants can be more challenging in virtual settings. Recognizing these challenges is important for ensuring fidelity and maximizing training impact.

Purpose of the Present Study

The intent of the current study was twofold: firstly, to determine whether the virtual and in-person formats of the ACT RSK Facilitator Training differed in terms of effectiveness and participant satisfaction, and secondly, to extract valuable insights for enhancing the quality and impact of virtual training sessions in future implementations. This study aims to contribute to the ongoing discourse regarding the efficacy of virtual training in the context of professional development and adult education, especially in fields related to child welfare and parenting.

Methods

Sample

Participants were 165 professionals who attended one of five ACT RSK Facilitator Trainings conducted between 2019 and 2022. The trainings were conducted by two ACT RSK Master Trainers with professionals from organizations that serve families, children, and communities, including schools, community mental health agencies, non-profit family service organizations, and child welfare-related programs.

All in-person trainings occurred prior to the COVID-19 pandemic, whereas all virtual trainings occurred during the pandemic, resulting in training format being confounded with year. Before the pandemic, three trainings were offered in person. During the COVID-19 pandemic time frame (2021-2022), one training was conducted virtually every year. Training classes were capped at an enrollment of 24 participants. Participants only enrolled in a single ACT RSK facilitator training session during the study period. Registration records indicated that individuals did not repeat the facilitator training. All participants in these trainings were included in the sample. Of the total sample, 69 participants attended a virtual facilitator training, and 96 attended an in-person facilitator training.

Measures

Pre- and post-training surveys were used to assess participants' perceived preparedness across core content areas of the ACT Raising Safe Kids (ACT RSK) intervention curriculum. The pre-training survey contained nine questions using a 5-point Likert scale ranging from "well prepared" to "very unprepared." Specifically, participants rated their readiness to address primary prevention intervention topics, including child development, aggressive behavior, violence, anger management, conflict management, discipline strategies, and media literacy. Participants also rated their preparedness to implement a program and work with individuals and families from diverse cultural, racial, ethnic, socioeconomic, and family-structure backgrounds, consistent with the program's emphasis on culturally responsive prevention practices. On the post-training survey, preparedness items were similar to those on the pre-training survey, except for one item. This post-training survey item differed from the pre-training survey item on preparedness to implement a program by asking participants to rate their readiness to implement the ACT RSK program with parents/caregivers in their community.

Overall satisfaction with the training experience was assessed using nine items included in the post-training survey. These items asked participants to rate their satisfaction with key aspects of the training, including the clarity of instructional content, usefulness of training materials, effectiveness of facilitation, and overall value of the training experience. Resource access and implementation likelihood items were rated on a 5-point Likert-type scale; access items ranged from "very adequate" to "very inadequate," and likelihood items ranged from

"very likely" to "very unlikely". Training satisfaction items were rated on a 6-point Likert-type scale, ranging from "strongly disagree" to "strongly agree," to allow for greater differentiation in participants' evaluative responses.

Procedure

Participants completed surveys at two time points: immediately prior to the start of the facilitator training (pre-test) and at the conclusion of the training session (post-test). This pre-test–post-test survey design was used to assess change in participants' self-reported preparedness. The same survey instruments were used across all training sessions and delivery formats. All trainings were facilitated by the same ACT RSK-certified Master Trainers, who followed the standardized ACT RSK curriculum and uniform survey administration procedures. This minimized variability in delivery. During in-person training sessions, participants completed the pre-test and post-test surveys using paper-and-pencil questionnaires administered on-site. For the virtual training sessions, participants completed the same pre-test and post-test surveys electronically via Qualtrics, a secure online survey platform. Survey links were provided to participants during the virtual training sessions in a Zoom chat box, and participants were given time during the session to complete each survey.

Additionally, the same PowerPoint slides, video demonstrations, and core audiovisual materials developed for the ACT RSK curriculum were used across both training formats. In virtual sessions, these materials were delivered via screen sharing and embedded digital features, whereas in-person sessions relied on projected audiovisual presentations. For the in-person trainings, audiovisual tools primarily consisted of projected slide presentations and video clips used during large-group instruction, supplemented by live discussion and role-play activities. In virtual trainings, these same core audiovisual materials were delivered via Zoom and supplemented with additional digital features, such as screen sharing, embedded videos, breakout rooms, and real-time chat functions. As a result, virtual sessions incorporated a greater number of audiovisual delivery modalities, although the underlying instructional content remained consistent across formats.

Since this was a retrospective study involving historical data analysis, a non-randomized, comparative design was adopted to examine group-level differences between training formats. Although formal controls for potential confounding variables (e.g., prior experience with virtual learning, comfort with technology, or baseline knowledge) were not included, the researchers assumed that the groups were similar, given their common interests in child welfare and parenting. This was supported by the lack of differences between the groups at pre-test. To ensure confidentiality, reduce social desirability bias, and secure truthful replies, all surveys were anonymous and did not collect identifying or demographic information. As a result, individual pre-test and post-test responses could not be linked at the participant level. Accordingly, analyses were conducted at the group level. Independent-samples t-tests compared virtual and in-person groups at both pre-test and post-test, and pre-tests with post-tests for both the virtual and in-person groups.

Results

Pre-test comparisons showed no statistically significant differences between virtual and in-person groups in preparedness to present program topics, implement the program, or work with diverse groups (see Table 1). The effect sizes for group differences were small. These findings suggest that both groups entered the training with similar levels of perceived preparedness.

Pre-test to post-test comparisons completed separately for each group showed that both had a significant increase on all perceived preparedness ratings at post-test, with medium effect sizes. These results suggest that overall, the training had a positive effect on preparedness to facilitate the ACT RSK prevention program (Tables 2 and 3).

On the post-test measure, there were no statistically

significant differences between groups for the majority of questions. A trending yet non-significant result of group differences pertained to the participants' preparedness to work with diverse groups (Table 4). The virtual group (M = 3.83, SD = 0.49) felt more prepared to work with diverse communities than the in-person group (M = 3.68, SD = 0.53); $t(163) = 1.84$, $p = 0.07$. Effect sizes for the posttest measures were small, suggesting no practical significance to the differences.

On all but one satisfaction measure, there were no significant group differences on satisfaction (Table 5). The groups did diverge significantly on satisfaction ratings when asked if using audiovisuals and PowerPoint slides enhanced the workshop. The virtual group (M = 4.99, SD = 0.12) had statistically significantly higher ratings than the in-person group (M = 4.81, SD = 0.49); $t(163) = 2.88$, $p = 0.01$, with a medium effect size (d = 0.46).

Discussion

The purpose of this study was to examine differences in participants' preparedness and satisfaction related to the delivery format of the ACT RSK Facilitator Training program. Overall, the findings indicated minimal differences in self-reported training outcomes across virtual and in-person formats. These results suggest that virtual facilitator training may be comparable to in-person training in preparing participants to deliver the ACT RSK intervention curriculum.

This interpretation aligns with prior research demonstrating that virtual training formats can effectively support professional learning, engagement, and skill development when used to train providers in evidence-based practices (Mak et al., 2015; Mullin et al., 2016). Importantly, these findings contribute to a growing body of literature on the viability of virtual training modalities for workforce development, particularly in mental health and social service settings where training accessibility and scalability are critical. Similar conclusions have been reported in studies comparing online and in-person formats for training clinicians and professionals in evidence-based psychological and health care practices (Mallonee et al., 2018).

Interpretation of Key Findings

A notable finding in this study was that participants in the virtual training group reported significantly higher satisfaction with the use of audiovisual tools, including PowerPoint slides, compared to participants in the in-person group. One plausible explanation is that the virtual format changes how audiovisual materials are delivered and interacted with. In the virtual sessions, core materials were presented directly through screen sharing, and participants could view the slides and videos at close visual range on their own devices. Virtual platforms also allow facilitators to integrate additional digital features such as embedded videos, real-time chat, and structured breakout-room activities, which may make the audiovisual components feel more integrated into the learning process rather than supplementary to it. In contrast, in-person sessions typically relied on projected slides and videos viewed from varying distances in the room and were more dependent on the physical training environment (e.g., sightlines, lighting, screen visibility). These delivery differences may help explain why participants perceived the audiovisual tools as more satisfying in the virtual format.

The finding also suggests that digital resources may be easier to implement consistently in virtual trainings, although they can be optimized in both formats. For example, in virtual sessions, video clips can be embedded and played within the same platform used for instruction, slides can be visible to all participants, and interactive elements such as polls or chat-based prompts can be incorporated in real time. In-person settings can also incorporate high-quality digital materials, but their effectiveness may depend heavily on room setup and technology logistics (e.g., projector quality, audio clarity, seating arrangement, and visibility). In this sense, the difference observed here may reflect not that digital materials are inherently better online, but that the virtual format may reduce variability in how participants access and perceive those materials.

Although most outcomes did not differ significantly by modality, the virtual group showed a nonsignificant trend toward higher perceived preparedness to work with diverse individuals and families. This pattern should be interpreted cautiously, given the lack of statistical significance, small effect size, and the absence of demographic data. One possible explanation is that virtual delivery may increase access for participants across a wider geographic area or from organizations serving different communities, which could broaden exposure to varied perspectives during group discussions. However, this interpretation remains tentative, and future studies that measure participant demographics and group composition directly would be needed to determine whether virtual trainings meaningfully influence perceived preparedness for culturally responsive work.

Implications for Practice

These findings have practical implications for organizations seeking to expand the reach and accessibility of their training programs. Virtual training formats offer several advantages, including cost savings, scheduling flexibility, and reduced geographical barriers, which may increase access for professionals in remote or underserved areas. By enabling broader participation regardless of location, virtual modalities can support wider dissemination of evidence-based parenting interventions, with the potential to positively influence community-level outcomes.

The higher satisfaction ratings associated with audiovisual use in virtual training suggest that online platforms may facilitate effective delivery of visual and interactive content. Given these results, implementing digital enhancements may further improve training outcomes. Examples of such enhancements include increased interactivity within presentations, such as embedded discussion prompts, live polls, or guided activities, as well as the inclusion of multimedia resources, such as video demonstrations, animated illustrations of core concepts, and interactive case-based scenarios. Strategic use of these features may enhance participant engagement and perceived value of training across both virtual and in-person formats.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the use of self-report measures may have influenced results, as participants' ratings of preparedness, satisfaction, and implementation intentions reflect subjective perceptions rather than objective indicators of skill acquisition or program effectiveness. In addition, preparedness and implementation likelihood were assessed using agree–disagree Likert-type items, which prior survey research has shown may be susceptible to acquiescence bias, potentially inflating positive responses (Saris et al., 2010).

Second, participants were not randomly assigned to virtual or in-person training formats. Training modality was determined by public health guidelines and organizational scheduling decisions during the COVID-19 pandemic. There may be unmeasured differences between the in-person and virtual groups related to receiving the training in different years. This limitation restricts the ability to draw causal conclusions regarding the impact of training format on satisfaction and preparedness outcomes. The finding that the groups did not differ on any variables on the pretest partially mitigates concern about this limitation.

Third, demographic and background information were not collected, limiting the ability to examine whether characteristics such as age, gender, prior experience with online training, or computer literacy moderated outcomes. Finally, the study did not assess the impact of technical challenges during virtual training sessions. Prior research suggests that technical difficulties can influence engagement, learning outcomes, and attrition in online training environments (Sitzmann et al., 2010). Participant self-selection may have had an influence on results, but this was likely minimal as the virtual and in-person training were not offered simultaneously.

Recommendations for Future Research

Future research should consider randomly assigning participants to virtual, in-person, or hybrid training formats when feasible. Random assignment would reduce self-selection bias and strengthen causal inferences regarding the effects of training modality on participant satisfaction, preparedness, and implementation intentions. It is important for future studies to also examine hybrid training models that combine virtual and in-person elements to determine whether they offer advantages over single-modality formats. Hybrid approaches may provide flexibility through remote access to digital materials while preserving opportunities for in-person interaction, which has been associated with enhanced engagement and learning outcomes (Ortiz et al., 2020).

Further research can also investigate whether participant characteristics, such as age, prior experience with digital tools, and computer literacy, moderate the effectiveness of virtual training. Examining these factors would help identify which participants benefit most from different training modalities and inform the development of more inclusive and accessible prevention training programs. Additionally, future studies can incorporate objective measures of learning outcomes, such as performance-based assessments, facilitator evaluations, or behavioral indicators of implementation fidelity. Combining objective measures with self-report data would allow for a more comprehensive evaluation of training effectiveness across delivery formats.

Conclusion

The present study contributes to the growing literature on virtual versus in-person facilitator training delivery formats for evidence-based prevention programs that use a "train the trainer" model. Findings indicated that virtual ACT Raising Safe Kids (ACT RSK) Facilitator Training produced levels of self-reported preparedness and implementation intentions comparable to those observed in traditional in-person training, while also yielding higher participant satisfaction with the use of audiovisual tools.

Taken together, the results suggest that virtual facilitator training represents a viable option for workforce development in prevention and parenting interventions. Virtual delivery may offer practical advantages, including increased accessibility, flexibility, and consistency in the use of digital training materials, which are particularly relevant for organizations seeking to expand training reach without compromising perceived training quality. Although virtual training is not inherently superior, it may reduce variability in how audiovisual resources are delivered and experienced across participants. As demand for accessible professional training continues to grow, virtual training modalities hold promise for strengthening workforce capacity and supporting broader dissemination of evidence-based prevention programs.



Table 1

Results of Pre-test Comparison of Virtual and In-person Training Groups on Perceptions of Preparedness to Present Program Topics

Topic	Virtual		In-person		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.00	0.89	2.97	0.82	0.21	0.84	0.03
Aggressive Behavior	2.66	1.02	2.50	0.89	1.04	0.30	0.17
Violence	2.81	0.88	2.81	0.90	0.73	0.47	0.12
Anger Management	2.71	1.04	2.48	0.90	1 55	0.12	0.25
Conflict Resolution	2.87	0.85	2.84	0.78	0.23	0.82	0.04
Positive Discipline	2.84	0.95	2.73	0.93	0.72	0.47	0.12
Media Literacy	2.43	0.91	2.23	0.88	1.41	0.16	0.22
Working Diverse Groups	3.22	0.85	3.34	0.78	-0.85	0.38	-0.14
Implementing a Program	2.70	0.96	2.68	0.99	0.18	0.88	0.03

Table 2

Results of Pre-test to Post-test Comparison of the Virtual Training Group on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.00	0.89	3.75	0.60	-5.73	<.001	-1.00
Aggressive Behavior	2.66	1.02	3.78	0.51	-8.06	<.001	-1.41
Violence	2.81	0.88	3.83	1.07	-8.21	<.001	-1.43
Anger Management	2.71	1.04	3.75	0.53	-7 50	<.001	-1.31
Conflict Resolution	2.87	0.85	3.80	0.53	-7.55	<.001	-1.32
Positive Discipline	2.84	0.95	3.80	0.53	-7.19	<.001	-1.25
Media Literacy	2.43	0.91	3.80	0.50	-10.81	<.001	-1.88
Working Diverse Groups	3.22	0.85	3.83	0.48	-5.07	<.001	-0.88

Table 3

Results of Pre-test to Post-test Comparison of the In-person Training Group on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.01	0.82	3.79	0.43	-8.24	<.001	-1.19
Aggressive Behavior	2.54	0.89	3.69	0.51	-11.01	<.001	-1.59
Violence	2.75	0.90	3.79	0.41	-10.29	<.001	-1.48
Anger Management	2.52	0.88	3.67	0.52	-11.01	<.001	-1.60
Conflict Resolution	2.86	0.77	3.76	0.48	-9.87	<.001	-1.42
Positive Discipline	2.77	0.93	3.81	0.39	-10.10	<.001	-1.45
Media Literacy	2.25	0.87	3.70	0.55	-13.90	<.001	-2.00
Working Diverse Groups	3.32	0.79	3.68	0.53	-3.66	<.001	-0.53

Table 4

Results of Post-test Comparison of Virtual and In-person Training Groups on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.75	0.60	3.79	0.43	-0.47	0.64	- 0.07
Aggressive Behavior	3.78	0.51	3.69	0.51	1.19	0.24	0.19
Violence	3.83	0.48	3.79	0.41	0.49	0.62	0.08
Anger Management	3.75	0.53	3.67	0.52	1.06	0.29	0.17
Conflict Resolution	3.80	0.53	3.76	0.48	0.47	0.64	0.07
Positive Discipline	3.80	0.53	3.81	0.39	-0.21	0.83	-0.03
Media Literacy	3.80	0.50	3.70	0.55	1.19	0.23	0.19
Working Diverse Groups	3.83	0.48	3.68	0.53	1.84	0.07	0.29
Implementing ACTRSK	3.64	0.64	3.53	0.58	0.27	0.27	0.18

Table 5

Results of Post-test Comparison of Virtual and In-person Training Groups on Satisfaction Ratings

Training Aspect	Virtual		In-person		t(163)	*p*	Cohen's d
	M	SD	M	SD			
Instructors Were Knowledgeable	4.97	0.17	4.98	0.14	-0.33	0.74	-0.05
Instructors Were Responsive	5.00	0.00	4.95	0.34	1.29	0.20	0.20
Adequate Discussion Opportunity	4.99	0.12	4.93	0.36	1.29	0.20	0.20
Discussion Contributed Greatly	4.91	0.51	4.85	0.39	0.85	0.40	0.13
Adequate Networking Opportunities	4.78	0.45	4.65	0.73	1.39	0.17	0.23
Program Materials Well Organized	4.76	0.58	4.99	0.12	0.76	0.45	0.12
AV/Powerpoint Enhanced Workshop	4.99	0.12	4.81	0.49	2.88	0.01	0.46
Small Groups Were Effective	4.84	0.59	4.82	0.50	0.21	0.84	0.03
Training Met Expectations	4.87	0.48	4.86	0.45	0.07	0.95	0.01



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Comparing In-Person and Virtual Trainings

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