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ABSTRACT
The STEERR Mentoring Framework, grounded in decolonized and feminist mentorship approaches, integrates foundational principles of mentoring with the unique and complex characteristics of the role of the forensic nurse. The primary objective of the program is to support a competent, sustainable, and resilient forensic nursing workforce. In this article, we describe the development process, framework structure, and evaluation approach implemented within a 1-year pilot initiative focused on forensic nurses in the sexual assault nurse examiner role. We reflect on strategies for broader application and replication in forensic nursing programs across the United States.

KEY WORDS:
Forensic nurse; mentoring; trauma informed; workforce capacity

In the United States, over half of women and nearly one in three men experience sexual violence involving physical contact in their lifetime (Centers for Disease Control and Prevention, 2022). The highest prevalence of sexual violence is experienced among ethnic minority populations, with 43.7% of non-Hispanic American Indian/Alaska Native and 48% of non-Hispanic multiracial women experiencing rape in their lifetime (Basile et al., 2022). Incidence of rape in the 12 months before survey completion was reported among U.S.-based non-Hispanic multiracial women (6.6%), non-Hispanic Black women (4.0%), non-Hispanic White women (2.0%), and Hispanic women (2.0%; Basile et al., 2022).

Systems of oppression, structural racism, and economic injustice further impact access and utilization of immediate, expert, and trauma-informed forensic nursing services, which when used are directly associated with healthier post-sexual-assault health outcomes among adolescent and adult populations (Bailey et al., 2017; U.S. Government Accountability Office [GAO], 2018; Nursing@Georgetown, 2019; Office for Victims of Crime [OVC], n.d.; Vogt et al., 2022). Historical traumas resulting from colonization and slavery collectively impact how and if survivors report sexual assault or access health care (Brave Heart, 1998, 2003; Danzer et al., 2016; Hampton et al., 2010; Rape, Abuse, & Incest National Network, 2019, 2020). There is a need to ensure healthcare delivery systems are reflexive, responsive,

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and considerate of the pervasive and dynamic context of sexual violence.

One national strategy to address barriers to accessing forensic services has been to increase the number of qualified forensic nurses delivering expert care to patients who present with concerns of sexual violence (U.S. Department of Health and Human Services, Health Resources and Services Administration [HRSA], 2021; OVC, n.d.). Although promising, this strategy may be undermined in the absence of:

- explicit, ongoing support focused on equipping the newly expanded forensic nursing workforce for long-term sustainability; and
- effective strategies that align culturally safe and responsive forensic nursing care by broadening and sustaining racial and ethnic diversity of the workforce (Kozhimannil et al., 2021; Phillips & Malone, 2014).

To operationalize additional solutions at the local level, we developed a mentoring intervention targeting the forensic nursing workforce. In this article, we reflect on the role and characteristics of the practice of mentorship as a clinical care and service delivery intervention, with the potential to directly and indirectly impact the long-term sustainability of forensic nurses through resilience and representation. We provide an overview of the development, initial use, and approach to evaluation of a mentorship framework we designed to mitigate the effects of health inequities within the context of forensic nursing practice. We reflect on successes, limitations, and ongoing adjustments to the model. Finally, we address next steps to broaden access to mentoring across forensic nursing.

### Background

Retention, resilience, and representation are factors intrinsically connected within the forensic nursing workforce that cannot be addressed in isolation. Forensic nurses in the sexual assault nurse examiner (SANE) role respond to the extensive and cumulative trauma held by the patients they serve. Secondary trauma, moral injury, burnout, and turnover are commonly experienced by forensic nursing providers. The U.S. GAO (2018) identified low SANE retention rates as a key challenge to providing high-quality care to survivors. Specific to our Midwest practice context, a Wisconsin-focused report estimated that of the 540 nurses trained as SANEs over a 2-year period, only 42 (~8%) remained in that specialty practice at the end of the 2-year period. The emotional and physical demands of SANE practice are cited as key contributors to low retention rates (U.S. GAO, 2018). Secondary traumatic stress is associated with negative life impacts including depression, anxiety, substance abuse, sleep disturbances, and physical symptoms (Raunick et al., 2015). Unaddressed, the professional demands on forensic nurses are associated with compromised well-being related to secondary traumatic stress (Raunick et al., 2015).

Representation in nursing is not solely recognized as a strategy to counter the impact of health inequities experienced by minoritized communities. A diverse workforce provides nuanced and unique perspectives and strategic expertise, critical for comprehensive understandings of and responses to the current and evolving patterns of sexual violence in the United States. Forensic nurses must provide specialized trauma-informed and culturally safe care that is responsive to patients laden with the trauma associated with the acute and often protracted violence they have endured. Patient trauma can include individual, familial, and community experiences of a tumultuous history with structures of power and oppression, including healthcare and law enforcement (Rape, Abuse, & Incest National Network, 2019, 2020). To address the issues surrounding trust and disrupting the perpetuation of historical trauma, the specialty of forensic nursing, and nursing in the United States generally, must be optimally representative of the communities most impacted by violence (Minority Nurse, 2013).

Despite the expansion of tools and resources within the forensic nursing discipline, and compelling evidence in support of mentoring as a tool to address retention, representation, and resilience more broadly, to date, there is an absence of mentoring interventions targeting the needs of forensic nurses in the SANE role. Although dated, a comprehensive literature review examining clinical nurse mentorship found no published articles describing mentorship among forensic nurses (Cashin & Potter, 2006). A more recent cluster of publications described the results of a workplace mentoring program where forensic nurses were mentored by senior nurses without forensic backgrounds over a 12-week period, as part of a larger resilience initiative (Davey et al., 2020; Henshall et al., 2020). Findings showed promise in confidence and problem-solving skills among forensic nurse mentees at program completion. There was no follow-up beyond the 12-week program, and the program itself was not customized to the forensic nursing context. Although, to our knowledge, these are the only published studies documenting the benefits of mentoring within forensic nursing, the convergence of interdisciplinary research and programmatic experiences supports the assumption that mentoring interactions targeted to the unique context of forensic nurses in the SANE role, with attention to health equity and workforce representation, may address urgent concerns in the field. Namely, mentoring interventions promote professional coping and resilience, recruitment and retention, and well-being, leading to sustainability in the role (Bouchard et al., 2022). Most fundamentally, connection with and support from other SANEs is an essential buffer against secondary traumatic stress, in addition to
its role in enhancing expertise and, presumptively, a positive impact on patient care.

Program Design and Implementation

STEERR Mentoring Framework Development
We identified literature grounded in mentoring best practices in practice-based disciplines as well as feminist and decolonized approaches to mentorship that described strengths-based and resilience-oriented models that promoted clinical and professional skill development through equitable partnership. Building on these guiding principles (Alarcón & Betzez, 2017; Curran et al., 2019; Fem-Mentee Collective et al., 2017; Lawson, 2007; Malone, 2021; Morrow, 2020; Mullings & Mukherjee, 2018), we established a priori a six-pillar approach to the mentorship relationship (see Table 1).

The STEERR (Strengths focused, Trust based, Eliminating barriers, Empowerment, Relationality, Reflexivity) program framework was developed on the praxis-based assumption that the most important form of self-care for a nurse practicing in the SANE role is access to a trauma-informed case debrief with another SANE. Our team viewed this as a fundamental to supporting sustainable SANE practice because it reinforces a connection with someone who has a shared professional experience and who understands the challenges associated with the profession and the need for a focus on self-care and mentorship. The interactions around case debrief and case discussion are foundational to this mentorship program. We also acknowledge the skills required to support a developing SANE, given each individual’s unique process toward expert practice, is a complex skill set. The framework was developed to address the needs of both mentors and mentees. Mentorship is a core component of our HRSA-funded workforce development initiative that is focused on strengthening the forensic nursing workforce specifically in underresourced and rural geographical areas. We present our development process, mentorship framework, initial promising results for mentors and mentees, and strategies for broader application and replication in forensic nursing programs across the United States. Although this work focused on new and developing SANEs, it can also inform forensic nursing practice more broadly.

The mentorship dynamic is purposefully and fundamentally mentee led. Mentors witness and support the mentee experience of becoming into the role of “trauma steward.” Trauma stewardship describes...

...anyone who interacts with the suffering, pain, and crisis of others or our planet. It is an approach that applies equally whether the trauma we encounter is glaring or subtle, sudden or prolonged, isolated or recurring, widely recognized or barely perceived. Our stewardship involves but is not limited to our intention in choosing the work we do, our philosophy of what it means to help others, the tone our caregiving takes, and our daily decisions about how we live our life. (Lipsky & Burk, 2009, p. 5)

The practice of trauma stewardship is reflected in the ways the mentor team came to define and enact the STEERR pillars in our program, relationships, and context. Stewardship, in the context of forensic nursing, is inclusive of trauma and healing centeredness and informs approaches within both of these paradigms.

STEERR Pilot Implementation

Inaugural Mentor Cohort
Individuals recruited to the inaugural mentor team represented diverse programs, geographies, and demographics. A noteworthy challenge was the underrepresentation of Black, Indigenous, and people of color mentors, a symptom of a larger problem in nursing in the United States (U.S. Department of Health and Human Services, HRSA, 2021). A key proximal impact of this racial imbalance of our team was that we were not able to ground our model in decolonized mentorship as fully as we intended (Alarcón & Betzez, 2017; Curran et al., 2019; Fem-Mentee Collective et al., 2017; Lawson, 2007; Malone, 2021; Morrow, 2020; Mullings & Mukherjee, 2018). This current imbalance would risk reinforcing and potentiating the same oppressive practices and systems that bolster inequities, the very patterns we seek to destabilize. In the current and future phases of this project, we actively seek to partner with SANEs who are Black, Indigenous, or people of color, to actualize a decolonized mentorship approach, and we are experiencing small successes.

Mentor interactions within the mentor community of practice were rich and praxis oriented, addressing gaps in understanding of the ways in which trauma-informed, evidence-based mentorship approaches existed in forensic nursing. The team met monthly in Year 1 and quarterly via Zoom. Through annual retreats, the team established in-person relationships.

Onboarding Process and Assessment of Mentee Goals
Mentees were a subset of members of RE Lab, a workforce development program focused initially on forensic nurses. RE Lab initially recruited members via word of mouth through a convenience sample, which led to an integrated snowball recruitment and promotion through a state-level forensic nurse advocacy listserv. Potential mentees were identified based on self-declared interest in mentorship involvement on a RE Lab member intake survey. The program coordinator made initial contact using a pre-scripted email template to request a 30- to 45-minute conversation. An interview guide was developed to discuss the potential mentee areas of interest in forensic nursing, goals for mentorship, and their overall context of practice and development. A
### TABLE 1. Fundamental Pillars of the STEER Mentoring Framework Derived From Decolonized and Feminist Mentoring Approaches

| STEERR mentoring framework | Mentorship facilitates resilience and sustainability as well as encourages and validates strengths and capabilities (Mullings & Mukherjee, 2018; Fem-Mentee et al., 2017). | We lead with an affirming position in the mentoring relationship. To develop confidence in each case and patient interaction, we work with mentees to establish an examination process and flow that mitigates feelings of intimidation and builds sustainability in practice. With our mentees, we establish that growth, leadership, and resourcefulness are equivalent to practice-based forensic nurse (FN) competencies in terms of importance. We introduce trauma-informed interviewing techniques inside the mentoring encounters to foster resilience, to reflect and model the ways in which these questions can be integrated in many contexts (including one’s own experiences), and to build understanding around the power of trauma-informed patient encounters. |
|---|---|
| Strengths focused | Trust is fundamental and underlies every interaction within this program. It begins with consistency, reliability, and authenticity. There is no judgment and no comparison between programs. As mentors, we are vulnerable. We share our mistakes and the lessons we have learned with the goal of benefiting mentees and sharing knowledge broadly to increase impact in our community. We acknowledge that trust in the group dynamic is essential—and we commit that all voices, even the softest, will be heard. | Trust mentorship is a reciprocal relationship of mutual respect and support rooted in vulnerability, empathy, and honest communication (Fem-Mentee Collective et al., 2017; Alarcón & Bettez, 2017; Morrow, 2020). |
| Trust | Mentorship is a collaborative, consensual, and coequal partnership that shares knowledge and mitigates power differences (Fem-Mentee Collective et al., 2017; Alarcón & Bettez, 2017). | Equalizing power is an explicit focus in our program. We make no assumptions of knowledge base and skill set as we begin our work with mentees and actively work to dismantle power structures of knowledge and experience—for example, assumptions about where high- and low-volume practice sites exist or resource availability. With mentees, we collaboratively establish a baseline understanding of their knowledge and experience, in addition to practice context, and commit to developing from that point. In sharing practice-based expertise, we recognize that there is no one right way to do things; we each have unique experiences and contexts within our practice. Knowledge is not owned; it is shared. We are all students, and we all have the innate ability to teach. We support mentees as they access and integrate their own unique knowledge and experience into the dyad and group relationships. |
| Equalizing power | (continues) |
### TABLE 1. Fundamental Pillars of the STEER Mentoring Framework Derived From Decolonized and Feminist Mentoring Approaches, Continued

<table>
<thead>
<tr>
<th>STEERR mentoring framework</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Eliminating barriers and hierarchy</strong></td>
<td>Mentorship analyzes and challenges institutional, cultural, and structural barriers and takes action to build mutuality and well-being (Curran et al., 2019; Lawson, 2007). We acknowledge the role of institutional, cultural, and structural barriers in shaping the experiences of developing FNs. We support mentees to identify and navigate barriers and engage in open and critical examination of factors that influence their patients’ experiences, their own professional experiences, and their personal responses to those experiences. The debriefing approach focuses on resiliency in these situations. We support the identification, naming, and navigation of the barriers mentees encounter and integrate strategies like planning, scripting, and role-playing. We reflect intentionally on emotional and physical feelings and how those feelings serve or challenge mentees. Through case studies, we build exposure and experience to support FNs as they meet the individual cultural needs of their patients, prioritizing a humanistic approach and culturally safe and responsive care.</td>
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<tr>
<td><strong>Relational</strong></td>
<td>Mentorship embodies the ethics and practice of trauma-informed care enacted in the nurse–patient relationship. Mentorship is centered in this holistic relational context, and this connection is translated to future patient encounters (Malone, 2021). We center trauma-informed care in every encounter and name that we carry our own trauma as we navigate the world. With this intentional recognition, we cultivate compassion for self and others. We prioritize the connection between mentors and mentees and work toward commonality—an understanding of where the individuals in the dyad are coming from and the direction they are going. We hold space and time for meaningful discussion, questioning, and discovery. Through the strength of connection, challenges are examined as opportunities for growth and honing skills. Mentors and mentees practice bidirectional learning, creating opportunities to listen and to be heard. Communication is multimodal, and as the dyad becomes attuned to one another, the opportunities to redirect, refocus, and further the caring relationship are more meaningful. Relational practices modeled in the mentorship relationship help mentors and mentees translate these practices to the patient care setting.</td>
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<tr>
<td><strong>Reflexive</strong></td>
<td>Mentorship examines the thoughts, feelings, and actions that construct our lived experiences and empowers the co-construction of expert practice and meaning-making (Fem-Mentee Collective et al., 2017; Morrow, 2020). The mentoring relationship is a unique dynamic the mentors and mentees build together. There is flexibility, adaptation, and nimbleness in the relationship, driven by mentees’ needs expressed in shared learning and discursive spaces. We process whatever comes up in the moment together. As questions and needs arise, we coexamine, respond, and iterate. This is a benefit of the structure of the program—it is not like reading a book, where there are no questions, no feedback. It is the job of the mentors to keep the overall goal of an interaction in mind and remain on target toward that goal. Our mentees come from very different practice settings and are unique people, so mentors’ approaches adapt with each mentee. As needs emerge, we emphasize the safety of connection and access and also honor the experience of mentee “becoming” in the role of FN, within their unique individual and practice contexts.</td>
</tr>
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Note. Pillars were initially defined based on prior studies and subsequently contextualized within the program through reflections and discussion among the inaugural cohort of mentors. STEERR = Strengths focused, Trust based, Eliminating barriers, Empowerment, Relationality, Reflexivity.
key inclusion criterion for the mentorship program was that the mentee self-reported a current SANE position. This ensured that the background knowledge necessary to fully participate in the program and the opportunity for application to practice were established immediately. The length of time the SANE had been in the position was not a criterion for inclusion in the mentorship program. Table 2 describes the demographic characteristics of our inaugural mentor and mentee cohort (Program Year 1), which comprised the data set for further evaluation and analysis.

Upon acceptance of the mentee to the program, a scripted email was sent to the potential assigned mentor with key demographic data collected at the intake survey and initial interview. The mentor then confirmed capacity, fit, and readiness to establish the dyad. The program coordinator facilitated an email connection between the mentor and the mentee through a scripted email, introducing the pair and requesting that they schedule the initial encounter to discuss the mentee’s current level of practice and to begin goal setting. A memo was signed by the mentee, the mentee’s program supervisor, and the mentoring coordinator that detailed these expectations. All encounters throughout the mentorship relationship were remote via the Zoom platform and recorded for transcription to facilitate fidelity and evaluative analysis.

**Mentorship Program Structure**

We implemented a co-mentorship small group structure (Borders, 2012; Mitchell et al., 2021) where two expert SANE mentors, and their corresponding mentees, partnered together. The intention behind this format was to center the primary relationship between the SANE mentor and mentee, while simultaneously building a network of practicing SANEs, where the relationality and collaboration would extend beyond the bounds of the program. We implemented a 1:2–3 mentor-to-mentee ratio to emphasize relationship building as well as programmatic feasibility. Mentees and mentors engaged in two primary types of interactions: (a) a monthly, 90-minute small group meeting consisting of the two mentors and their mentees; and (b) monthly 1:1 encounters intended to focus on a debrief of a forensic examination and ideally occurring within 72 hours of the patient encounter.

At a minimum, the mentor–mentee dyad had one encounter every month during the small group meeting. A sample schedule of group meeting topics is presented in Supplemental Digital Content 1, http://links.lww.com/JFN/A122. Over time, particularly for mentees in low-volume programs where cases were infrequent, we observed a number of dyads holistically innovate an additional 1:1 encounter. This took the form of (a) an open discussion; (b) a mock case; (c) a secondary debrief of a case that was presented to the mentee outside of the context of the mentoring program, which the dyad processed through together; or (d) a mentor case review. This naturalistic evolution informed the structure and composition of the STEERR toolkit, which includes a body of mock cases developed by the project mentors to support the most prominent types of interactions and needs mentees brought to the mentoring relationship. In the absence of a mentee case debrief, the mock case supported content for the standard 1:1 mentor–mentee interaction, regardless of whether the mentee performed a SANE examination.

The case debrief approach was designed for the purpose of professional development of SANE mentees. The case debriefs did not serve any additional purpose, such as quality control or clinical consult. It was explicit that the case debriefs did not contain any protected health information.

Evidence supports the role of a structured, prompt debriefing in simulated/preservice/novice training and orientation (not limited to the field of nursing). We anticipated that a portion of mentees enrolled in the mentorship program would not have access to a structured, prompt case debrief with a trusted, expert SANE mentor. However, even when mentees did have access to a structured, prompt debrief within their programs, the team of mentors collectively determined mentor case debriefs still held significant importance, because of the value multiple viewpoints brought to the learning experience and the potential for a different power dynamic with an external thinking partner. Furthermore, the National Sexual Assault Protocol (Office on Violence Against Women, 2013, p. 26) encourages quality review processes that ensure a high-quality, coordinated response to patients who have experienced sexual assault.

**Mentee Completion**

We asked that mentees commit to a minimum of 6 months of mentorship. We initiated discussions around mentorship completion at 12 months, although this was highly individualized. Evidence broadly supports 12 months of mentorship in nursing (Hoover et al., 2020); however, forensic nursing is unique in that it is an episodic, call-based position with significant variability in patient presentation. Our mentor team realized the frequency of mentor–mentee interactions served as an indicator of mentee readiness, which nearly equated to “time in program.” Additional key indicators of mentee readiness identified by mentors included time in program, the number of mentee/mentor interactions, case volume, the characteristics of base programs (e.g., presence
Therewas not a standard timeline or set of requirements for completion. The mentor assessed for ongoing full engagement and value added in continuing participation. Upon completion of the mentorship program, the mentor referred the mentee to the program coordinator for a final structured interview and discussion of resources to scaffold a supported transition out of the program. Conversations about transition resources for mentees included the option of an ongoing, isolated case debrief with a mentor and opportunities to support the mentee transition into a precepting, mentor, or leadership role within their base program.

### Evaluation Approach

We implemented a two-pronged approach to program evaluation. The first was a practical approach to programmatic
processes using the Concerns-Based Adoption Model (CBAM), which we describe below. This guided the formative evaluation and refinements during the implementation year of STEERR. The second approach included critical exploratory, descriptive, and interpretive analyses of dyad interactions in mentorship spaces; the vacillation in and out of those spaces; and how pairs positioned each other in relationships that facilitated transformation in actions, practices, and behaviors. The protocol was submitted to the University of Minnesota Institutional Review Board before implementation and was determined to be exempt from review.

Evaluation of Programmatic Processes
The CBAM evaluation structure supported the recognition and interpretation of mentee progression as well as how mentors adapted their individualized relational and transformative coaching approaches based on this. CBAM tools supported an understanding of the engagement of nurses developing in the SANE role specifically in relation to critical elements of SANE practice that the project team identified during program development. CBAM provided a structure, within which observations of mentorship groups initiating their negotiations around the intervention change path were made. The CBAM evaluation structure is composed of three evaluative domains that are tailored to the unique context and program: innovation configuration (IC), stages of concern, and levels of use.

Innovation Configuration
The initial step in the application of CBAM to STEERR was the development of the IC, which we refer to in the program as SANE Practice IC (see Table 3; Hoffman et al., 2022; Hord et al., 2006). Five dimensions, or transdisciplinary resources, facilitated a complex process of disaggregating SANE practice into the six critical components of the SANE Practice IC. The guiding frameworks and dimensions of the SANE Practice IC included principles of the neurobiology of trauma, Herman's trauma and recovery framework (Herman, 2015), principles of the forensic/medicolegal framework, the National Protocol for Sexual Assault Medical Forensic Examinations (OVC, 2013), and the AACN Framework for Cultural Competency in Nursing Education (American Association of Colleges of Nursing, 2009). The SANE Practice IC functioned as the basis of goal setting and practice-oriented discussions key to the SANE examination and also served as a guide to address specific components that were consistently challenging or problematic for the SANE mentee. Although the initial critical components of the SANE Practice IC remained static, mentorship dyads had an option to develop “related” components through the program. The tool itself functioned as a changeable model—sensitive, through mutual adaptation, to the unique patient care context and tangible elements of practice that each mentee experienced.

Using the SANE Practice IC as a tool, mentors and mentees were able to target strategies for professional development that built mentee confidence and self-efficacy. Mentors gained more knowledge about mentee goals across the domains, which informed how encounters in the mentoring program were shaped. Mentors revisited the SANE Practice IC with mentees in various ways that were dependent on the relationship and mentorship style. This included its use as a means for regular, focused assessment or at program midpoint as a high-level formative assessment of the change path. The SANE Practice IC was initiated as a qualitative programmatic tool and later evolved into both a qualitative and quantitative self-assessment utilized by mentees as well as members in the broader project.

Stages of Concern
Through the Stages of Concern tool, dyads examined and addressed the perspectives and feelings of the mentee as that individual progressed through the transition into or the advancement in SANE practice (George et al., 2006; Newlove & Hall, 1976). These assessments were made through monthly surveys where mentees were asked to share “open-ended concerns statements.” The program surveyed all mentees with two questions: (a) What are your top 3 concerns right now, related to your role as a SANE? and (b) What is something you are really excited about? Surveys were distributed within 72 hours of the small group mentorship meetings, where mentors had a chance to review and integrate responses into the small group discussions. An example of a mentee progression within the Stages of Concern statements, with references to ways the mentor was addressing and adapted process to support stated needs, is presented in Supplemental Digital Content 2, http://links.lww.com/JFN/A123.

Levels of Use
Levels of use is a structured interview that follows an algorithm assessing uptake of each critical component of the SANE Practice IC (Hall et al., 2006). We integrated the optional interview as a summative evaluation of program impact, to balance the SANE Practice IC and Stages of Concern survey. Upon program completion, the mentorship program coordinator (who was not directly connected with any one mentorship group) conducted the interview via the Zoom platform. The team used the aggregate findings from the interviews as one formative evaluation strategy to adjust program structure and emphasis to maintain alignment with the overarching objectives of the STEERR program.

Exploratory and Descriptive Approach of Co-Constructed, Discursive Mentorship Spaces
To answer questions about how mentors and mentees positioned themselves and each other in relationships, and how mentees were approaching and transforming through actions, practices, and behaviors, the study team applied
### TABLE 3. SANE Practice Innovation Configuration Map: Key Features of SANE Practice

#### Component 1: SANE provides trauma-informed, victim/survivor-centered care

<table>
<thead>
<tr>
<th>Optimal practice</th>
<th>Expected practice</th>
<th>Not yet part of practice</th>
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<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Prioritizes emotional and psychological needs of the patient at the level of or beyond procedural examination elements and adapts examination accordingly. Evidence of effort to build rapport, identifies preferred name and uses gender-affirming language. Introduces strategies to promote patient sense of safety. Documents patient affect, emotion, and response to examination. Emphasizes privacy and confidentiality. Utilizes trauma-informed interview strategies. Includes advocacy. Examination length appropriate to the case.</td>
<td>Addresses all examination elements listed in (A), although with varying degrees of completeness. Readily prioritizes the emotional and psychological needs of the patient.</td>
<td>Emotional and psychological needs considered, although SANE prioritizes procedural examination processes. Rapport and patient sense of safety prioritized after procedural elements. Examination length compromises victim-centered care, although examination is accurate and thorough. Documentation is procedural; patient affect and emotion are captured but are less prominent or included in certain areas of the examination only. Evidence of trauma-informed interview strategies in examination. Steps are correct, although opportunities to appropriately adapt procedures to the needs of the patient may have been missed.</td>
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#### Component 2: SANE shows culturally responsive/culturally sustaining care

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<tr>
<td>A</td>
<td>B</td>
<td>C</td>
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<tr>
<td>Shows a critical awareness of one’s own knowledge and biases of culturally diverse populations. Develops effective communication strategies and skills that foster trust with individuals from diverse backgrounds. Implements evidence-informed forensic assessment and treatment of sexual assault in the context of diverse clinical presentation.</td>
<td>Clear progress in the development of knowledge and bias, aware of personal limitations that could function as barriers to culturally responsive and culturally sustaining SANE practice, but actively working to surface and resolve limitations. Shows communication strategies and skills that foster trust with individuals from diverse backgrounds.</td>
<td>Shows awareness and motivation though practice remains situated within the ethnic majority paradigm, the status quo, and the comfort zone of the SANE.</td>
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#### Component 3: SANE shows complete and accurate documentation of the patient encounter

<table>
<thead>
<tr>
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<th>Not yet part of practice</th>
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<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
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<tr>
<td>Uses quotes extensively to emphasize patient voice; uses accurate, forensic terminology; presents comprehensive, objective and subjective clinical assessments; high-quality photographs with accurate and corresponding description organized clearly in the chart; includes accurate forensic description of the injury.</td>
<td>Quotes used extensively but may lack clarity or specificity; forensic terminology used appropriately most of the time; subjective and objective clinical assessments are appropriate but may lack detail; photography and associated documentation is acceptable; accurate forensic description of injury included most of the time.</td>
<td>Quotes are used, but impact is lessened by a lack of completeness, detail, placement, and clarity; forensic terminology present but may be inaccurate or incomplete in places; subjective and objective clinical assessments are appropriate but vary in degree of completeness; photography and associated documentation is sufficient.</td>
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### TABLE 3. SANE Practice Innovation Configuration Map: Key Features of SANE Practice, Continued

#### Component 4: SANE integrates a coordinated team approach

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<th>Optimal practice</th>
<th>Expected practice</th>
<th>Not yet part of practice</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td><strong>B</strong></td>
<td><strong>C</strong></td>
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<tr>
<td><strong>Effectively coordinates care team and initiates appropriate referrals including case management, social work, advocacy; communicates effectively with primary provider and other pertinent staff; evidence of discharge planning in chart (e.g., prescriptions, follow-up appointments, safety plan, referrals).</strong></td>
<td><strong>Integrates a coordinated team approach with essential resources, may miss opportunities to integrate peripheral or external collaborators; communicates effectively with primary provider and staff; evidence of discharge planning where most of the key patient needs are addressed.</strong></td>
<td><strong>Attempts to integrate a coordinated team approach readily apparent, where key elements of approach are missed or lacking; evidence of discharge planning where most of the key patient needs are addressed.</strong></td>
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#### Component 5: SANE provides tailored and focused forensic physical examination

<table>
<thead>
<tr>
<th>Optimal practice</th>
<th>Expected practice</th>
<th>Not yet part of practice</th>
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</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td><strong>B</strong></td>
<td><strong>C</strong></td>
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<td><strong>Conducts a comprehensive head-to-toe assessment consistent with a documented narrative report of assault; recommends appropriate medications; collects all appropriate swabs and maintains the integrity of those swabs; shows knowledge of timing of medication administration and swab collection; appropriately assesses, documents, and manages degree of case complexity; takes appropriate steps to address injury; correctly completes administrative steps including required forms, packaging of forensic evidence, and engagement with law enforcement/legal partners.</strong></td>
<td><strong>Head-to-toe assessments include the most crucial elements to the case and is nearly comprehensive, with minor elements not documented or completed; recommends appropriate medications; collects all appropriate swabs and maintains the integrity of those swabs, where minor deviations to the process do not impact examination quality and/or are documented; clear assessment and documentation of case complexity, examination tailored appropriately; shows knowledge of timing of medication administration where variation from expected protocols or procedures occur, results does not/have minor impact on the quality (e.g., collects oral swabs after 24 hours); takes appropriate steps to address injury; administrative steps complete, where most elements of steps are completed correctly.</strong></td>
<td><strong>Head-to-toe assessments include the most crucial elements to the case but may not be comprehensive or portions may not be aligned with the narrative report of the assault; recommends appropriate medications; collects most of the swabs that are relevant to the case and maintains the integrity of the swabs and/or documents if/when the integrity of swabs is compromised; acceptable understanding of case complexity, examination tailored somewhat; shows knowledge of timing of medication administration and swab collection, where variation from expected protocols or procedures occur, results does not/have minor impact on the quality (e.g., omits fingernail swabs when memory lapse is present but no report/signs/symptoms of strangulation); takes most steps to address injury, may omit consults when appropriate; administrative steps mostly complete, or most elements completed correctly.</strong></td>
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(continues)
exploratory, interpretive, and descriptive analytic methodologies. These evaluation strategies supported the examination of variations in social, racial, linguistic, and geographic contexts as well as ways that mentors actualized essential program constructs in the space of forensic nursing and SANE practice. Critical discourse analysis was responsive to questions surrounding how pairs constructed and then moved in and out of the mentorship space—and ways discourses supported this positionality.

### Successes and Shortcomings

Mentors and mentees have overwhelmingly expressed a recognition and commitment to the value and experience within the program, specifically the bidirectionality of the relationships, the variety of platforms supporting interaction (e.g., individual and group), access to experiences and perspectives external to the home program, opportunities to nurture an observed “hunger” for knowledge and practice expertise, a safe and supported outlet, and intentionality around building networks and communities of practice. The team has invested extensive energy into the development, customization, and implementation of tools to support the mentoring relationship and the mentee experience. This inevitably compromised the capacity of the team to prioritize mentor preparation and coaching. Although mentors were recruited based on experience, expertise, and demonstrated capacity to thrive in the role of mentor, teaching and learning styles varied. In Year 1, where mentee needs were anticipated, the needs of mentors to function most effectively in the program were largely responsive. As this was recognized, and the goal of supporting mentees through completion of the program and subsequently into the role of mentor was realized, the team initiated an emphasis on formalizing a supported mentor onboarding pathway.

### Implications for Forensic Nursing Practice

The 1-year STEERR implementation and evaluation period resulted in a refined mentorship curriculum and toolkit as well as a framework for mentor preparation that will be formalized in upcoming project phases. We tailored a robust, pragmatic evaluation model and established a plan for the dissemination of scientific inquiry surrounding the ways in which mentors enacted STEERR framework constructs in the unique space of forensic nursing. We gathered the experiences of mentees at various points in the program and continue to track outcomes post-mentoring-program completion, including indicators of well-being, job satisfaction, and retention in forensic nursing. The resulting curriculum is the first trauma-informed, mentee-led program of mentorship targeted to forensic nurses practicing in the SANE role. Next steps include the development of a conceptual model from the six STEERR pillars to provide programs a more concrete roadmap in support of implementation. We envision the customized application of STEERR across areas of forensic nursing such as intimate partner violence, strangulation, and pediatric forensic care.

System-level supportive strategies, such as reflexive and responsive mentorship, hold promise to address the challenges of retention, representation, and resilience in the forensic nursing workforce. Our model offers noteworthy strengths that, with further implementation and evaluation, could significantly position forensic nursing as a model for establishing and maintaining a sustained and expert workforce that effectively and responsibly serves all people, in potentially their most exposed and difficult moments.

### References


