Reviewer’s report

Title: Questionnaires on stigmatizing attitudes among healthcare students in Taiwan: Development and validation

Version: 0 Date: 14 Jul 2019

Reviewer: Claire Henderson

Reviewer's report:

Suggest rephrase 'negative knowledge' e.g. lack of knowledge

'Particularly for occupational therapy'- this implies the scale is for or mainly for occupational therapy students, but this is not clear. Clarify whether this is the aim in the abstract and the end of the introduction - at the moment it is not clear until the start of the methods.

People with mental illness are not usually in need of long term health care- do the authors mean severe mental illnesses, such as psychosis and bipolar disorder? Even for these illnesses the course of illness is highly variable, e.g with many people having a single episode of psychosis and no further problems.

For the methods I think the scale development should be described first and then the methods for how its properties were evaluated.

For scale development, the sample size required is based on what is needed to evaluate the psychometric properties of the scale. I did not understand why it is instead based on the size of the population.

There are already a number of scales developed to assess stigma in healthcare professionals and/or students including Opening Minds Stigma Scale for Health Care Providers (OMS-HC) and Mental illness Clinicians’ Attitudes scale (MICA), or which have been used in healthcare professionals because of greater suitability than many of those developed for the general population- for example the scale developed by Crisp et al which asks about specific diagnoses. While these might require adaptation they seem a more obvious place to start than those used. Were they identified by the searches? If so what was the rationale for not using them? If not, I think the searches were deficient.

No reference is made to standards for psychometric assessment such as the Terwee criteria. The authors acknowledge the lack of validation however there is no 'gold standard'- instead scales measuring related constructs e.g. mental health literacy can be used for convergent validity and unrelated constructs for divergent. I take the point about respondent burden but for example there are measures of desire for social distance which could have been used, the shortest of which is just 4 items, i.e. the intended behaviour subscale of the RIBS (Evans-Lacko et al).

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

**Does the work include the necessary controls?**
If not, please specify which controls are required in your comments to the authors.

Yes

**Are the conclusions drawn adequately supported by the data shown?**
If not, please explain in your comments to the authors.

Yes

**Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?**
If an additional statistical review is recommended, please specify what aspects require further assessment in your comments to the editors.

I recommend additional statistical review

**Quality of written English**
Please indicate the quality of language in the manuscript:

Acceptable

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