



This is a repository copy of *A scoping literature review on minimum intervention dentistry for children with dental caries.*

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/188027/>

Version: Accepted Version

Article:

Dawett, B. orcid.org/0000-0001-7299-7266, Deery, C. orcid.org/0000-0001-7526-7736, Banerjee, A. et al. (2 more authors) (2022) A scoping literature review on minimum intervention dentistry for children with dental caries. *British Dental Journal*. ISSN 0007-0610

<https://doi.org/10.1038/s41415-022-4038-8>

This is a post-peer-review, pre-copyedit version of an article published in the *British Dental Journal*. The final authenticated version is available online at:

<https://doi.org/10.1038/s41415-022-4038-8>

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Title : A scoping literature review on Minimum Intervention Dentistry for children with dental caries.

Authors:

Bhupinder Dawett, BDS MDPH, Doctoral Research Fellow, School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield, S10 2TA.

Chris Deery, BDS, MSc, FDS RCSEd, PhD, FDS(Paed Dent) RCSEd, FDS RCSEng, FHEA, Dean, Professor/Honorary Consultant in Paediatric Dentistry, School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield, S10 2TA.

Avijit Banerjee, BDS, MSc, PhD(Lond), LDS FDS (Rest Dent), FDS RCS (Eng), FHEA, Professor of Cariology and Operative Dentistry/Honorary Consultant, Restorative Dentistry, Faculty of Dentistry, Oral & Craniofacial Sciences, King's College London, London, UK.

Diana Papaioannou, BChD, MSC, CTRU Assistant Director, School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent St, Sheffield S1 4DA

Zoe Marshman, BDS, MPH, DDPH, PhD, FDS DPH, Professor in Dental Public Health, School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield, S10 2TA.

Words 4290

Figures 2

Tables 2

Corresponding author : **Bhupinder Dawett**, b.k.dawett@sheffield.ac.uk

Abstract:**Background:**

Dental caries in children's permanent teeth remains a global burden. In contrast to the traditional approach of treating the disease through surgical operative intervention, Minimum Intervention has increasingly been recommended for managing children with dental caries.

Aim:

This scoping review aimed to describe the literature related to the provision of minimum intervention dentistry for children with caries and identify research gaps.

Methods:

Electronic databases (Medline via Ovid, Pubmed, Web of Science, and Scopus) were searched, together with grey literature databases, and key organisation websites. Data was extracted on a piloted extraction template, and a thematic analysis was undertaken.

Results:

Sixty-seven relevant articles were identified. No empirical literature was identified that assessed a complete minimum intervention care pathway to managing caries. Five themes were identified from the scoping literature: evidence base, clinician attitude and skills, practice implementation, acceptability and environmental factors.

Conclusions:

The majority of articles were opinion papers. There is a paucity of empirical evidence supporting the clinical and cost effectiveness of a minimum intervention pathway for children with dental caries in primary dental care. The scoping review has identified some

potential barriers to the implementation of such a care pathway, including regulatory and remunerative frameworks and clinical training / education.

Background

Dental caries is one of the most common non-communicable diseases (NCDs) worldwide and remains a significant public health problem. The Global Burden of Diseases study 2017 reported that untreated dental caries was the most prevalent condition, with 2.3 billion people affected by untreated dental caries in permanent teeth, and for primary teeth 532 million children affected ⁽¹⁾. In the United Kingdom, it is one of the most common childhood NCD with nearly a half of 15-year olds and a third of 12-year olds having obvious decay experience in their permanent teeth and follows social gradients with the most deprived being more affected ⁽²⁾.

Management of dental caries has been addressed traditionally using a mechanistic, surgical operative approach ⁽³⁾. This approach has typically involved the removal of all the affected tooth tissue usually under a local anaesthetic and restoration by filling the cavity with a restorative material. The use of a drill and injections are procedures commonly reported by children as causing anxiety and fear. Furthermore, dental restorations in permanent teeth have a finite longevity and replacements are required periodically. This places the tooth and the patient in a cycle of lifelong restorative care, frequently leading to the eventual loss of the tooth ⁽⁴⁾.

Advances in the understanding of the caries disease process have shown that carious lesions in the early stages can be reversed ⁽⁵⁾, together with an understanding that dentine-pulp complex reactions are protective, promoting the maintenance of tooth vitality. These,

coupled with advances in dental biomaterials and adhesion, underpinned by the fact that dental restorations have a finite lifespan, support the management of a patient with dental caries in a more minimally invasive operative manner.

Different terminology appears to be used for this approach ⁽⁶⁻¹⁰⁾; throughout this article we use the term Minimum Intervention Dentistry. There is variation surrounding the components of minimum intervention dentistry ⁽¹¹⁾ and how this approach can be implemented for children with established dental caries presenting in primary care ⁽¹²⁻¹⁶⁾. The aim of this scoping review was to describe the literature related to the provision of minimum intervention dentistry for children with caries and identify research gaps.

Methods

A scoping review was undertaken according to the approach developed by Arksey and O'Malley ⁽¹⁷⁾. For this scoping review of minimum intervention dentistry and children with carious teeth the research question was "What is the nature of the literature on minimum intervention dentistry and children with caries?". The clinical scope was kept broad to capture as much literature in this area as possible since the aim was to identify what literature existed, and the research gaps. Literature relevant to the target population of children defined as under 18 years old was included.

A search was conducted on electronic databases including Medline via Ovid, Web of Science, Pubmed, and Scopus. After a preliminary search, the terms "minimum intervention" OR "minimal intervention" were used with the term "dentistry" or "caries" to

identify relevant evidence. These keywords were felt to cover the range of terms used for techniques following a minimum interventive approach. The search was limited to articles in the English language due to translation costs and time available. Articles published between 1970 to September 2020 were included since the term “minimum intervention dentistry” was commonly used from the 1990s; thus 1970 allowed a large leeway. Databases that searched for grey literature were included, Open Grey and Ethos.

The inclusion criteria were:

- The keywords “minimum intervention “or “minimal Intervention” being included in the title and or abstracts or as keywords.
- All types of research design (randomised control trials, cohort trials, case-control studies, cross sectional studies, opinion articles)
- Articles in English Language
- Articles published from January 1970 to September 2020.

The exclusion criteria were papers:

- Relating solely to clinical conditions other than dental caries.
- Relating solely to cosmetic dentistry and or facial aesthetics
- Published before 1970
- Where abstracts and texts could not be obtained
- In languages other than English
- Where MID was not or could not be related to children.
- Describing in-vitro or animal based studies.

Reference lists and manual searching was conducted. Certain UK-based organisation's websites were also searched to identify relevant literature, including British Dental Association (BDA), National Institute for Health and Care Excellence (NICE), Faculty of General Dental Practitioners United Kingdom (FGDP UK) , and General Dental Council UK (GDC).

The papers were processed in Endnote and duplicates removed. A data extraction spreadsheet was designed using the initial topics and themes from a preliminary literature review. The data extraction form was piloted (BD, ZM, CD) on five articles in order to aid consistency and agreement. The initial themes that were identified from the literature review were discussed and further themes were added to the data extraction form.

An optional sixth stage, that of a consultation exercise, is advocated by Arksey and O'Malley⁽¹⁷⁾. Levac et al propose that the consultation stage improves the academic rigour and is an essential component in a scoping review⁽¹⁸⁾. The consultation stage aimed to help identify any relevant missed literature, to provide further insights into the findings of the scoping review and help prioritise future research. The consultation stage involved group and individual discussions, with purposively selected groups of stakeholders. These stakeholders included four practice owners, three associate dentists (from three different NHS dental practices), two dental therapists (from two dental practices), a dental nurse, practice manager and six patients who were part of a patient and public group meeting.

Results

The electronic searches from the databases revealed a total of 753 papers; 338 duplicates were removed. After removal of these duplicates, the remaining 415 articles had their titles screened to see if they were applicable to the area of study. Those that showed relevance to the topic of minimum intervention dentistry and caries were further assessed. Abstract screening revealed 139 papers that required full text screening. Sixty-three articles were included from the electronic search results. Hand searching using reference lists identified four further articles. In total, 67 papers satisfied the inclusion criteria. A flow chart of the search and screening process is detailed in figure 1.

Fig 1. Flow chart of the search strategy.

Article characteristics

Of the 67 included articles, the first authors of the articles were from a variety of countries. Australia (n=18) and the UK (n=17) were the most common countries of origin with France (n=9), and the United States of America (n=5) the next most frequent.

Publications were from 24 different journals. The most common journal of publication was the British Dental Journal (n=23), with the Australian Dental Journal (ADJ) the next most frequent (n=12).

Results showed that most of the studies were opinion papers (n=48), with six reporting a randomised control trial (RCT), seven questionnaire-based cross-sectional studies, one interview-based qualitative study, one retrospective cohort study, and four reviews (two systematic reviews and two literature reviews).

“Components” included in minimum intervention dentistry

The included papers were investigated for the components of minimum intervention dentistry they included. Components were placed into domains of a) detection, b) diagnosis, c) prevention, and d) minimally invasive interventions. As some components were applicable in more than one domain, they were included in all relevant domains (Figure 2) .

Fig 2. Components included in the domains of minimum intervention dentistry.

Detection

Twelve components were used or described in the literature for the detection stage of minimum intervention dentistry. As expected, the visual and tactile method of detection was the most common method advocated (n=23). Radiography was also advocated in 14 papers. The use of the International Caries Detection and Assessment System (ICDAS) was included in 14 papers. The use of additional detection aids such as light fluorescence were advocated by 14 papers.

Diagnosis

The inclusion of a caries risk assessment tool appeared in 21 papers. These advocated the use of a structured caries risk assessment (CRA) method with Caries Management By Risk Assessment (CAMBRA) being the most common (n=8). Other CRA tools included the Cariogram (n=5). The use of salivary tests as part of a CRA were included in twelve papers. Also the use of light fluorescence technology appeared in three papers.

Prevention

The literature has identified several components that may be used alone or in combination. The most common professional intervention was fluoride varnish (n=23), followed by oral health education (n=14), fissure sealants (n=13: resin based sealants (n=9) and glass ionomer-based sealants (n=9)).

Minimally invasive interventions

Minimally invasive interventions and techniques included adhesive restorative materials (n=28), Atraumatic Restorative Treatment (ART) (n=17) and micro-invasive management of

non-cavitated lesions (n=8). With regards to how much caries should be removed, selective caries removal appeared as the most common (n=14), with the stepwise technique mentioned in two papers. A number of caries removal instruments were specifically mentioned including air-abrasion (n=6), chemo-mechanical (n=6), and sono-abrasion (n=5).

In summary, the literature revealed broad agreement that the principal domains of minimum intervention dentistry were detection / diagnosis (identifying the problem), prevention, minimally invasive operative interventions and recall. The stages of detection and diagnosis were often combined as one domain. There were a wide range of components that could be included to execute each domain.

Analysis of papers by “theme”

Five themes, four of which were sub-divided into sub-themes, emerged from the scoping review literature (see Table 1). Several papers expressed more than one theme.

Table 1. Themes identified affecting the delivery of minimum intervention oral care and number of papers in each sub-theme.

1. Evidence base

There were three sub-themes highlighted: limitations of the traditional approach, the clinical effectiveness and the cost effectiveness of minimum intervention dentistry. The

scoping review identified several papers, mainly opinion pieces, that criticised the traditional approach to caries management and highlighted its potential disadvantages when compared to minimum intervention and its components ⁽¹²⁻¹⁶⁾. While the review found several opinion pieces that claimed minimum intervention dentistry was effective based on evidence from its individual components ^(15, 19-23), the scoping review failed to identify any definitive trials of the efficacy or effectiveness of a complete minimum intervention care pathway for children with dental caries in their permanent teeth. Two papers described randomised control trials (RCTs). However, they evaluated the Atraumatic Restorative approach (ART) and did not include other minimum intervention domains ^(24, 25). These studies stated that the ART was as effective as conventional treatment. Similarly, while many articles suggested the cost-effectiveness of minimum intervention was important, no health economic evaluations were conducted. This theme highlights the large gap in the literature into the clinical and cost effectiveness of minimum intervention pathways in primary dental care compared to standard care.

2. Clinical skills and attitude

This theme, which included 27 papers, was sub-divided into two subthemes, i) clinicians' attitudes and knowledge and ii) teaching and education. The majority of papers included in this theme were opinion papers. The empirical papers consisted of two cross-sectional studies and one qualitative paper. There was an apparent lack of knowledge amongst primary dental care clinicians about the minimum intervention approach and some suggestion of reluctance on their behalf to learn to deliver it particularly when the evidence base in primary dental care was perceived to be lacking. The impact of historical undergraduate teaching in favouring the traditional surgical approaches over minimum

intervention may be influencing this perception. It was suggested that minimum intervention training needs to be more prevalent in undergraduate programmes and postgraduate courses, with hands-on practical experience favoured.

3. Implementation in primary dental care

Theme three included two subthemes: i) the current use of minimum intervention in primary dental care and ii) the utilisation of the whole oral healthcare team. The literature, mostly opinion pieces, suggested that the current use of the minimum intervention pathway in primary dental care was low although many of the individual techniques/procedures are used separately. The literature generally advocates utilisation of the whole oral healthcare team to deliver it although randomised control trials were only available for dental therapists using ART ⁽²⁶⁻²⁸⁾.

4. Acceptability to patients and parent/carers

Acceptability of minimum intervention to patients and parent/carers is a recurring theme including empirical questionnaire-based studies ^(19, 29-32), and authors state that minimum intervention offers a more 'patient friendly' approach to caries management. A trial conducted in public health clinics in Australia by Arrow and Klobas assessed acceptability of the ART compared to the standard care approach ⁽²⁸⁾. The study utilised a facial image scale based questionnaire and found similar levels of dental anxiety between the two arms.

5. Environmental factors

This includes sub-themes of a) regulatory and remunerative frameworks and b) medico-legal concerns. The scoping review identified the regulatory and remuneration system as an important factor that will impact on the implementation of minimum intervention oral care delivery. Remuneration systems appear to reward dental professionals better for itemised restorative treatments than for prevention ^(14, 33-37). Similarly, medico-legal concerns about changing clinical practice to a minimum intervention approach may be a factor that impacts provision by clinicians. Opinion papers have suggested the risk of litigation of such a minimum intervention approach was low ^(38, 39). This is based on the presumption that a minimum intervention care pathway is a “well proved and well accepted” procedure ⁽³⁸⁾, also being well established. Such an argument is open to debate given the lack of definitive research supporting this.

Stakeholder consultation

The results described above were discussed during a consultation with Public and Patient Involvement (PPI) groups and dental professional stakeholders. The stakeholders were able to discuss the themes and endorse the areas for future research relating to minimum intervention dentistry. In addition, they identified several other gaps including:

- the importance of research relating to the progression of caries.
- the costs of delivering minimum intervention in primary dental care including equipment costs, costs associated with training of the oral healthcare team and any building alterations required.
- children’s perspectives on the appearance of teeth.
- The environmental impact of minimum intervention dentistry compared to traditional approaches.

In summary, the stakeholder consultation stage of the scoping review supported the results and added valuable insights to inform future research.

Summary and the research gaps

The scoping literature has identified several gaps in the research and uncertainties regarding the minimum intervention care pathway. These are summarised in the table 2. There were no studies found that assessed the whole minimum intervention care pathway versus the traditional approach for managing children with caries in their permanent teeth.

Table 2 . Summary of research gaps identified by a review of the scoping literature.

Discussion

This scoping literature review is the first to describe the literature related to the provision of minimum intervention dental care for children with caries. It aimed to identify related themes and research gaps to inform future research. The majority of articles were opinion papers and the review found no empirical studies that assessed implementation and acceptability of the whole minimum intervention care pathway.

Previous randomised control trials performed in general practice have assessed healthcare interventions as single entities without considering that they form part of a care pathway

delivered to patients in a complex environment. In clinical settings, healthcare delivered by professionals including dental professionals can consist of a number of different interventions under varying contextual influences. These cannot really be said to be just simple interventions that should be looked at in isolation. For example, treatment of a carious cavity in an individual would involve detection, diagnosis, risk assessment, consultation with the patient regarding preferences, possibly care delivered by differing dental professionals and maybe even in a variety of environments. Complex interventions are common in the health service setting and their evaluations pose specific challenges. The Medical Research Council has published guidance on developing, evaluating and implementing complex interventions, and this field is evolving ^(40, 41).

Minimum intervention care as described above is a complex longitudinal intervention made up of several interacting components within defined domains, delivered possibly in different organisational settings, with several outcomes of interest, involving variable stakeholder behaviours and tailored to the individual patient.

The literature highlighted the variation between authors in the terminology and components of minimum intervention dentistry. While many opinion pieces describe minimum intervention dentistry as an evidence-based approach, there remains a lack of research on its clinical and cost-effectiveness compared to usual care. This may be due to the historic focus on individual components of minimum intervention delivery. However, it should be regarded as a complex longitudinal intervention comprised of interacting domains ⁽¹¹⁾ and so evaluation of the whole pathway is required⁽⁴²⁾. For example, if detection of carious lesions is not optimal at baseline, then analysis of clinical outcome measures at final

follow-up may show reduced effectiveness of an intervention with no significant difference from a control. In practice, this is important and an understanding of how one domain can affect another in any care pathway is important.

An important aim of the scoping review was to identify gaps in the literature which will help to design future studies and help plan implementation of minimum intervention care. Gaps included undergraduate training, impact of regulatory and remunerative frameworks, workforce skill mix and medicolegal aspects ⁽⁴³⁾.

In this review, no papers were found to focus on children and their carers' perspectives of minimum intervention dentistry. For patient-focused care, the views of children and carers must be considered and explored. The stakeholder consultation suggested that the aesthetic impact should be included which may require child-focused research approaches with children and their parents/carers ⁽⁴⁴⁾.

The search methods for this review focused on searching for studies that discussed or evaluated the entire minimum intervention pathway. As such, the many terms used to describe minimum intervention dentistry would be identified in the electronic searches using the broad search terms described in the method section. However, a potential limitation of this review is that separate searches were not conducted for each individual domain of minimum intervention. A search of the literature for all domains, including minimally invasive dentistry, would result in a huge number of articles but likely add little to the scoping review findings. Reference list checking, grey literature searching and stakeholder and consultation with two cariologists were also conducted to limit omission of

key articles. The inclusion of English language only articles may also be a limitation of the review.

The lack of consensus of terminology can cause not only difficulty when searching for literature, but also when trying to understanding what components may be included. The term “minimally invasive dentistry” may also compound the problem. In 2016, the FDI updated their policy on minimal intervention dentistry as “to conserve remineralisable and intact tooth tissue to help retain teeth throughout life. Tooth tissue should not be removed unnecessarily. The major components include: 1) early detection of carious lesions and assessment of caries risk and activity; 2) remineralisation of demineralised enamel and dentine; 3) optimal measurements to keep sound teeth sound; 4) tailor-made dental recalls; 5) minimally invasive operative interventions to ensure tooth survival; 6) repairing rather than replacing defective restorations”.

Moving forward the terms “Minimum Intervention Oral Care” and “ Minimally Invasive Dentistry” have been presented to further try to clarify this discipline. Minimum intervention oral care (MIOC) has been defined as individualised patient care delivery, with responsibilities from the oral healthcare team and patient, using research and development in disease detection and diagnosis, susceptibility assessment, prevention / control regimes and minimally invasive operative treatments, with the goal of maintaining lifelong oral health. The term minimally invasive dentistry (MID) is now solely used to describe all operative interventions at the tooth-level which should be biological, respecting and preserving dental/oral hard & soft tissues, being as minimally destructive as possible. State-

of-the-art operative technologies / bioactive materials should be mastered and used. This is one of the 4 interlinking domains that make up the MIOC framework ⁽⁴⁵⁾.

Conclusions

The majority of articles about minimum intervention dentistry and caries in children were opinion pieces with limited empirical studies. The scoping review consistently identified a minimum intervention care pathway to consist of the domains of detection & diagnosis, prevention, restoration and recall. It also shows that several components can be included in these domains. Themes that were identified were evidence base, clinical skill and attitude, practice implementation, acceptability and environment influences. There is a paucity of evidence supporting the clinical and cost-effectiveness of minimum intervention for children with dental caries in primary dental care. In addition, several other gaps in the research were identified including effectiveness, acceptability and barriers to implementation. A controlled trial to determine the clinical and cost-effectiveness of the entire minimum intervention oral care pathway in children is required. However, the scoping review identified factors to consider in implementation and acceptability of minimum intervention dentistry. Further feasibility work would help provide insight into key parameters before conducting a full-scale trial.

Declaration of interests

The project was funded by the National Institute for Health Research (NIHR) through a Doctoral Research Fellowship. The views and opinions expressed by the authors in this publication are those of the authors and do not necessarily reflect those of the NIHR.

Author Contribution Statement

BD, CD, AB, DP, and ZM contributed towards the conception of the design. BD, DP, ZM contributed towards data acquisition and analysis. All authors contributed towards interpretation, drafted and critically revised the manuscript.

Conflict on Interest

None to disclose

References

1. Collaborators GBDOD, Bernabe E, Marcenes W, Hernandez CR, Bailey J, Abreu LG, et al. Global, Regional, and National Levels and Trends in Burden of Oral Conditions from 1990 to 2017: A Systematic Analysis for the Global Burden of Disease 2017 Study. *J Dent Res.* 2020;99(4):362-73.
2. Pitts N, Chadwick B, Anderson T. Child Dental Health Survey 2013 Report 2. Dental Disease and Damage in Children England, Wales and Northern Ireland. London. Health and Social Care Information Centre. 2015 NHS Digital: @NHSDigital; 2013 [Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/children-s-dental-health-survey/child-dental-health-survey-2013-england-wales-and-northern-ireland>].
3. Black GV. A work on operative dentistry. Chicago: Medical Dental Publishing; 1908.
4. Elderton RJ. The prevalence of failure of restorations: a literature review. *J Dent.* 1976;4(5):207-10.
5. Koulourides T, Feagin F, Pigman W. Remineralization of dental enamel by saliva in vitro. *Ann N Y Acad Sci.* 1965;131(2):751-7.
6. Dawson AS, Makinson OF. Dental treatment and dental health. Part 1. A review of studies in support of a philosophy of Minimum Intervention Dentistry. *Aust Dent J.* 1992;37(2):126-32.
7. Dawson AS, Makinson OF. Dental treatment and dental health. Part 2. An alternative philosophy and some new treatment modalities in operative dentistry. *Aust Dent J.* 1992;37(3):205-10.
8. FDI. FDI policy statement on Minimal Intervention Dentistry (MID) for managing dental caries: Adopted by the General Assembly: September 2016, Poznan, Poland. *Int Dent J.* 2016;67(1):6-7.
9. Frencken JE, Peters MC, Manton DJ, Leal SC, Gordan VV, Eden E. Minimal intervention dentistry for managing dental caries - a review: report of a FDI task group. *International Dental Journal.* 62(5):223-43.
10. Tyas MJ, Anusavice KJ, Frencken JE, Mount GJ. Minimal intervention dentistry--a review. FDI Commission Project 1-97. *International Dental Journal.* 50(1):1-12.
11. Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M, et al. Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ.* 2008;337:a1655.
12. Banerjee A. 'MI'opia or 20/20 vision? *Br Dent J.* 2013;214(3):101-5.
13. Banerjee A. 'Minimum intervention' - MI inspiring future oral healthcare? *British Dental Journal.* 2017;223(3):133-5.
14. Calache H, Hopcraft MS, Martin JM. Minimum intervention dentistry - A new horizon in public oral health care. *Australian Dental Journal.* 2013;58(SUPPL.1):17-25.
15. Featherstone JDB, Doméjean S. Minimal intervention dentistry: Part 1. from 'compulsive' restorative dentistry to rational therapeutic strategies. *British Dental Journal.* 2012;213(9):441-5.
16. Innes NP, Manton DJ. Minimum intervention children's dentistry - the starting point for a lifetime of oral health. *Br Dent J.* 2017;223(3):205-13.
17. Arksey H, O'Malley L. Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice.* 2005;8:19-32.

18. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implement Sci.* 2010;5:69.
19. de Menezes Abreu DM, Leal SC, Mulder J, Frencken JE. Pain experience after conventional, atraumatic, and ultraconservative restorative treatments in 6-to 7-yr-old children. *European Journal of Oral Sciences.* 2011;119(2):163-8.
20. Freitas MFL, Santos JM, Fuks A, Bezerra ACB, Azevedo TDPL. Minimal Intervention Dentistry Procedures: a Ten Year Retrospective Study. *Journal of Clinical Pediatric Dentistry.* 2014;39(1):64-7.
21. Mandari GJ, Frencken JE, van't Hof MA. Six-year success rates of occlusal amalgam and glass-ionomer restorations placed using three minimal intervention approaches. *Caries Res.* 2003;37(4):246-53.
22. Mickenautsch S, Yengopal V. Extent and quality of systematic review evidence related to minimum intervention in dentistry: essential oils, powered toothbrushes, triclosan, xylitol. *Int Dent J.* 2011;61(4):179-92.
23. Tyas MJ, Anusavice KJ, Frencken JE, Mount GJ. Minimal intervention dentistry - a review - FDI Commission Project 1-97. *International Dental Journal.* 2000;50(1):1-12.
24. Mandari GJ, Frencken JE, Van't Hof MA. Six-year success rates of occlusal amalgam and glass-ionomer restorations placed using three minimal intervention approaches. *Caries Research.* 2003;37(4):246-53.
25. Mandari GJ, Truin GJ, van't Hof MA, Frencken JE. Effectiveness of three minimal intervention approaches for managing dental caries: survival of restorations after 2 years. *Caries Research.* 2001;35(2):90-4.
26. Arrow P, Klobas E. Minimum intervention dentistry approach to managing early childhood caries: a randomized control trial. *Community Dent Oral Epidemiol.* 2015;43(6):511-20.
27. Arrow P, Klobas E. Child oral health-related quality of life and early childhood caries: a non-inferiority randomized control trial. *Aust Dent J.* 2016;61(2):227-35.
28. Arrow P, Klobas E. Minimal intervention dentistry for early childhood caries and child dental anxiety: a randomized controlled trial. *Australian Dental Journal.* 2017;62(2):200-7.
29. Arrow P, Klobas E. Minimal intervention dentistry for early childhood caries and child dental anxiety: a randomized controlled trial. *Aust Dent J.* 2017;62(2):200-7.
30. Brennan DS, Balasubramanian M, Spencer AJ. Restorative treatment for initial, cavitated and gross coronal carious lesions. *Aust Dent J.* 2016;61(3):350-6.
31. Burke FJT, McHugh S, Shaw L, Hosey MT, Macpherson L, Delargy S, et al. UK dentists' attitudes and behaviour towards Atraumatic Restorative Treatment for primary teeth. *British Dental Journal.* 2005;199(6):365-9.
32. Frencken JE. Atraumatic restorative treatment and minimal intervention dentistry. *Br Dent J.* 2017;223(3):183-9.
33. Dawett B, Atkins B, Banerjee A. A guide to building 'MI' oral healthcare practice. *Br Dent J.* 2017;223(3):223-7.
34. Doméjean S, Banerjee A, Featherstone JDB. Caries risk/susceptibility assessment: its value in minimum intervention oral healthcare. *Br Dent J.* 2017;223(3):191-7.
35. Mickenautsch S. An introduction to minimum intervention dentistry. *Singapore Dent J.* 2005;27(1):1-6.
36. Mickenautsch S, Rudolph MJ. Minimal intervention dentistry (MI) for South Africa. *SADJ.* 2004;59(8):327, 9.

37. Schwendicke F, Foster Page LA, Smith LA, Fontana M, Thomson WM, Baker SR. To fill or not to fill: a qualitative cross-country study on dentists' decisions in managing non-cavitated proximal caries lesions. *Implement Sci.* 2018;13(1):54.
38. D'Cruz L. Dento-legal considerations about an MI approach. *Br Dent J.* 2017;223(3):199-201.
39. Mackenzie L, Banerjee A. Minimally invasive direct restorations: a practical guide. *Br Dent J.* 2017;223(3):163-71.
40. Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. *Int J Nurs Stud.* 2013;50(5):587-92.
41. Craig P, Petticrew M. Developing and evaluating complex interventions: reflections on the 2008 MRC guidance. *Int J Nurs Stud.* 2013;50(5):585-7.
42. Squires JE, Valentine JC, Grimshaw JM. Systematic reviews of complex interventions: framing the review question. *J Clin Epidemiol.* 2013;66(11):1215-22.
43. Brocklehurst PR, Williams L, Burton C, Goodwin T, Rycroft-Malone J. Implementation and trial evidence: a plea for fore-thought. *Br Dent J.* 2017;222(5):331-5.
44. Marshman Z, Gibson BJ, Owens J, Rodd HD, Mazey H, Baker SR, et al. Seen but not heard: a systematic review of the place of the child in 21st-century dental research. *Int J Paediatr Dent.* 2007;17(5):320-7.
45. Banerjee A. Minimum intervention oral healthcare delivery - is there consensus? *Br Dent J.* 2020;229(7):393-5.

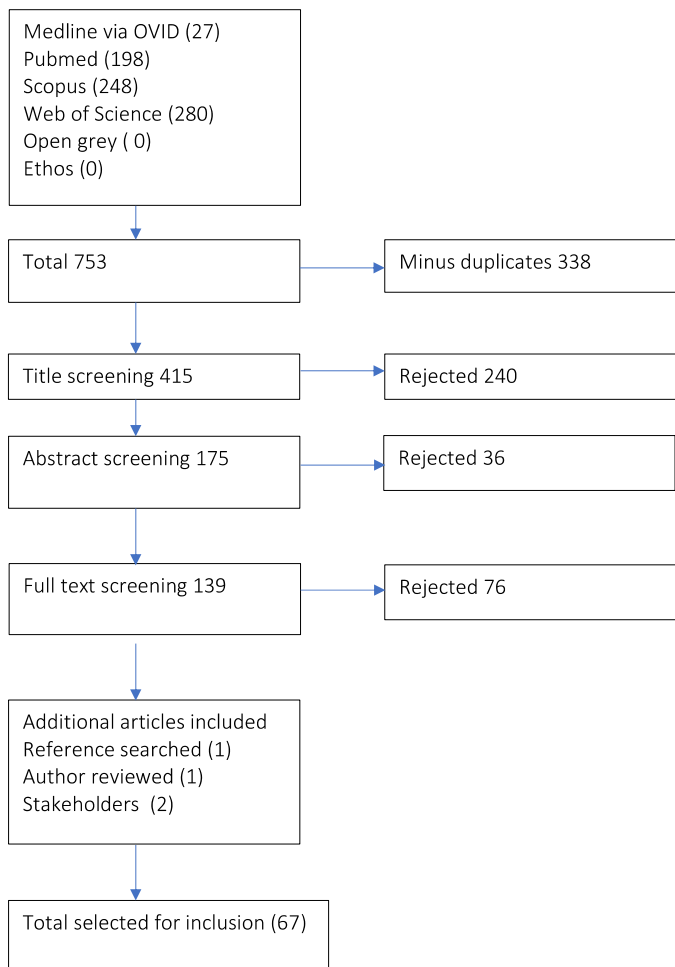


Fig 1. Flow chart of the search strategy.

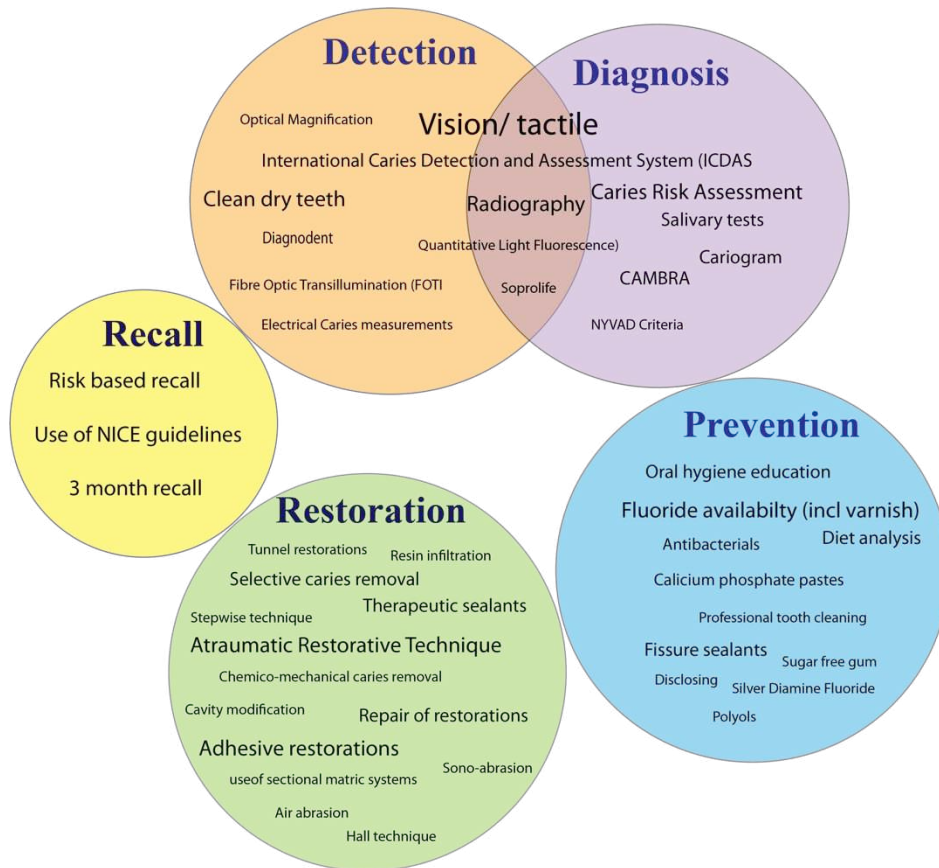


Fig 2. Components included in the domains of minimum intervention dentistry.

	Theme	Number of articles
1	Evidence base	
	Subtheme 1(a). Limitations of traditional approach	23
	Subtheme 1(b). Clinical effectiveness of minimum intervention	30
	Subtheme 1(c). Cost effectiveness of minimum intervention	7
2	Clinical skills and attitude	
	Subtheme 2(a). Clinician attitude and knowledge	16
	Subtheme 2(b). Teaching and education	13
3	Practice implementation	
	Subtheme 3(a). Oral healthcare team workforce	16
	Subtheme 3(b). Current practice provision of minimum intervention	21
4	Patient and parent/carer acceptability	20
5	Environmental factors	
	Subtheme 5(a). Regulatory and remunerative frameworks	22
	Subtheme 5(b). Medico-legal concerns	3

Table 1. Themes identified affecting the delivery of minimum intervention oral care and number of papers in each sub-theme.

Themes identified	Current research literature and gaps
Limitations of traditional approach	Mainly opinion-based and no high quality studies evaluating minimum intervention pathway vs traditional approach
Clinical effectiveness	Opinion papers advocate potential benefit Empirical studies advocated possible benefit of ART. No research identified on the clinical effectiveness of the whole minimum intervention care pathway v traditional approach.
Cost effectiveness	No empirical studies that have assessed cost effectiveness of the minimum intervention care pathway.
Clinician attitude and knowledge	Literature indicates that GPs knowledge of minimum intervention dentistry may be poor. No high quality study of this with regards to members of the oral healthcare team in primary care dental practice in the UK.
Teaching and education	Opinion papers have suggested that the teaching of minimum intervention dentistry may be poor. Empirical data show lack of knowledge of ART amongst UK dentists.
Dental team workforce	The opinion papers advocate the use of dental therapists for the delivery of minimum intervention dentistry. Empirical studies have just used dental therapists for the ART approach. NO studies have evaluated the use of dental care professionals (DCPs) in the delivery of the minimum intervention care pathway.
Current practice provision of minimum intervention	Opinion papers have stated that minimum intervention is poorly implemented. Empirical studies would support this. No research on the provision of the whole minimum intervention care pathway in general dental practice in the UK.
Acceptability	Opinion papers advocate that minimum intervention dentistry is a more acceptable to patients. Empirical studies have shown some potential of ART to be more accepted by patients. No research has been identified that assessed patient and parent acceptability of a whole minimum intervention care pathway.
Regulatory and remunerative factors	Opinion papers have stated that these would be a potential barrier to minimum intervention care pathway delivery. Some support from a qualitative study. No research has assessed how regulatory and remunerative factors could affect the delivery of a whole minimum intervention care pathway.
Medico-legal implications	Opinion papers highlighted that medico-legal concerns may be a factor in minimum intervention care pathway delivery. No research has been identified that assessed how medico-legal concerns can affect the delivery of the minimum intervention care pathway.

Table 2 . Summary of research gaps identified by a review of the scoping literature.