Early Intervention Orthodontics (Phase 1)

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Early Intervention Orthodontics (Phase 1 / Interceptive Treatment)

What Is Early Intervention Orthodontics?

Early intervention orthodontics — sometimes called Phase 1 orthodontics or interceptive orthodontic treatment — refers to orthodontic treatment carried out during a child's development, typically between the ages of 7 and 11, while a mix of primary (baby) and permanent teeth are still present.

The goal of interceptive treatment is not necessarily to complete all tooth alignment at this stage — that is usually addressed in a second phase of treatment during or after the eruption of all permanent teeth. Rather, early intervention targets specific skeletal or dental problems that are easier, less invasive, and more effective to correct while a child's jaws are still growing. If left until growth is complete, some of these problems require either more complex orthodontic treatment or surgical correction.

Not every child needs early intervention. The decision to treat — or to wait and monitor — is a clinical judgement that only a specialist orthodontist is qualified to make. At Collins Street Specialist Centre, early intervention treatment is recommended only when there is clear clinical evidence that intervening now will produce a meaningfully better outcome than waiting.

When Might a Child Need Early Intervention?

The American Association of Orthodontists recommends that all children have an orthodontic assessment by age 7. In Australia, a similar principle applies — a specialist orthodontic consultation during the mixed dentition phase allows problems to be identified at a stage when the most can be done about them.

Signs that may indicate a child would benefit from early orthodontic assessment:

- **Crossbite** — particularly a front-tooth crossbite (underbite), where upper and lower teeth meet abnormally. Treating this early can prevent progressive jaw asymmetry. - **Posterior crossbite** — where the upper back teeth bite inside the lower back teeth on one or both sides, which can cause the

jaw to shift sideways and create facial asymmetry over time - **Severe crowding** — insufficient space for permanent teeth to erupt, potentially causing teeth to erupt in ectopic (abnormal) positions or impaction - **Significant overjet** — upper front teeth that protrude markedly, increasing the risk of trauma to those teeth and sometimes associated with a skeletal jaw discrepancy - **Early loss of baby teeth** — through decay or trauma, which can cause adjacent teeth to drift and space to be lost - **Thumb or finger sucking beyond age 5–6** — prolonged digit habits can alter jaw shape and tooth position - **Mouth breathing and airway concerns** — associated with specific jaw growth patterns that are more amenable to intervention during growth - **Tooth impaction** — particularly canine teeth that are on an abnormal eruption path and may be redirected with early space management - **Narrow upper jaw** — a constricted palate that is causing crowding, crossbite, or bite problems - **Delayed eruption or retained baby teeth** — may indicate underlying problems with permanent tooth development

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What to Expect: Step by Step

Orthodontic Assessment The assessment begins with a clinical examination, including evaluation of tooth eruption, bite, jaw relationship, and facial profile. Radiographs — typically an OPG showing all developing teeth and a lateral cephalogram assessing jaw position — are reviewed. Digital photographs and in some cases an intraoral scan may be taken. Your specialist orthodontist will discuss findings and whether treatment is recommended at this stage, or whether a monitoring program is more appropriate.

Monitoring Without Treatment In many cases, the most appropriate recommendation is active surveillance — scheduled review appointments (typically 6 to 12 monthly) to monitor tooth eruption and jaw development without active treatment. This is not a default position; it is a clinical decision made when the evidence indicates that waiting will produce equivalent or better outcomes.

Treatment Planning for Phase 1 When early intervention is warranted, a customised treatment plan is developed based on the specific problem being addressed. This might involve one or more of the following appliance types:

- **Palatal expander (rapid maxillary expansion)** — a fixed or removable appliance that gradually widens the upper jaw, used for narrow palates causing posterior crossbite or severe crowding. Most effective during childhood when the mid-palatal suture is unfused. - **Space maintainers** — prevent neighbouring teeth from drifting into spaces created by premature loss of baby teeth - **Partial braces** — brackets on a limited number of teeth to correct specific problems such as a front crossbite - **Functional appliances** — removable or fixed devices that modify jaw position and growth in children with significant overbite or underbite related to jaw size discrepancy - **Clear aligners for children** — Invisalign also offers a children's product (Invisalign First) for certain early-phase indications

Phase 2 Treatment Early intervention does not eliminate the need for a full course of orthodontic treatment later. Most children who have Phase 1 treatment will proceed to a Phase 2 course of treatment (typically full braces or aligners) once all permanent teeth have erupted. Phase 1 may shorten the complexity or duration of Phase 2, and can prevent outcomes that would otherwise require surgery.

Recovery and Aftercare

Appliance comfort varies with the device used:

- **Palatal expanders** require an adjustment period of one to two weeks. Children typically adapt well. An activation key is used by a parent to turn the expander by the prescribed amount daily or every few days. Mild discomfort or pressure during activation is normal. - **Partial braces** produce the same

adjustment experience as full braces — mild soreness for a few days after placement and after each adjustment appointment - **Functional appliances** are generally bulkier and take one to two weeks to adapt to, particularly for speech

Oral hygiene remains critical regardless of which appliance is used. Children will need supervised brushing and assistance with cleaning around appliances. Regular dental check-ups with the child's general dentist should continue throughout orthodontic treatment.

After early intervention treatment, retainers or passive holding appliances may be provided to maintain the correction achieved while the child continues to grow and develop.

Why See a Specialist Orthodontist?

The decision of whether, and when, to treat a child orthodontically is one that requires a thorough understanding of growth and development — not just tooth position. A specialist orthodontist has completed three or more additional years of postgraduate training specifically in orthodontics, including the study of craniofacial growth, tooth eruption patterns, and how skeletal and dental changes interact over time.

General dentists can identify obvious orthodontic problems and refer appropriately, but the diagnosis, treatment planning, and management of interceptive orthodontic treatment should be in the hands of a registered specialist. The distinction matters most in early intervention, where an incorrect decision to treat — or not to treat — at the wrong time can have lasting consequences.

CSSC specialist orthodontists work closely with the practice's paediatric dentists (specialist paedodontists on Level 8), who often co-manage young patients with complex dental and orthodontic needs. If a child requires behaviour management, treatment under sedation, or management of dental development concerns such as hypomineralisation or enamel defects, both specialties are accessible under one roof.

Our Orthodontic Specialists

Early intervention orthodontic treatment at Collins Street Specialist Centre is provided by:

- **Dr David Austin** — BDSc (Melb), MDS Orth (HK), MOrth RCS (Edin). Experience with children and adults across the full range of orthodontic treatment. - **Dr Andrea Phatouros** — BDSc (WA), MDSc Orth (WA), FRACDS. Postgraduate teaching in orthodontics at undergraduate and postgraduate levels. - **Dr Joshua Ch'ng** — BDSc (Melb), FRACDS, D.Clin.Dent (Melb). Specialist training at the University of Melbourne with research in digital orthodontic records and imaging. - **Dr Steven Smith** — BDSc (Hons), MDSc (Ortho) (Qld). Specialist orthodontist trained at the University of Queensland.

All four are registered specialists with the Dental Board of Australia. Verify specialist registration at AHPRA (ahpra.gov.au).

Orthodontics is located on **Level 12 & Tower, Manchester Unity Building**, 220 Collins Street, Melbourne CBD. No referral is required — parents can book directly for a child's orthodontic assessment.

Related Treatments

- [Traditional Metal Braces](/orthodontics/braces/) — Phase 2 fixed appliance treatment following early intervention - [Invisalign](/orthodontics/invisalign/) — clear aligner options including Invisalign First for suitable early presentations - [Surgical Orthodontics](/orthodontics/surgical-orthodontics/) — for

skeletal problems that cannot be resolved by orthodontics alone once growth is complete - [Paediatric First Dental Visit](/paediatric-dentistry/first-dental-visit/) — information on specialist paediatric dental care and its overlap with orthodontic development