Early Intervention Orthodontics (Phase 1)

Canonical: https://directory.collinsstreetspecialistcentre.com.au/procedures/orthodontics/early-intervention-orthodontics-phase-1/

Description:

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...

Details:

Collins Street Specialist Centre Early Intervention Orthodontics (Phase 1 / Interceptive Treatment)

What is early intervention orthodontics?

Collins Street Specialist Centre provides early intervention orthodontics — also called Phase 1 orthodontics or interceptive orthodontic treatment — which describes orthodontic care delivered during a child's active development, typically between ages 7 and 11, while both primary (baby) and permanent teeth are still present.

The goal at this stage isn't to complete full tooth alignment. That's ordinarily handled during a second phase of treatment, once all permanent teeth have come through. Early intervention targets specific skeletal or dental problems that are more straightforwardly and effectively corrected while a child's jaws are still growing. Left until growth is complete, these problems may require considerably more complex orthodontic treatment or surgical correction.

Not every child needs early intervention. Whether to treat now or wait is a clinical judgement that only a specialist orthodontist is qualified to make. At Collins Street Specialist Centre, early intervention is recommended only when there's clear clinical evidence that acting now will produce a meaningfully better outcome than deferring.

When might a child need early intervention?

Australian orthodontic best practice recommends that all children have an orthodontic assessment by age 7. A specialist consultation during the mixed dentition phase allows problems to be identified while the greatest range of options is still available.

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

- **Crossbite,** particularly a front-tooth crossbite (underbite), where upper and lower teeth meet abnormally. Addressing this early can prevent progressive jaw asymmetry from developing. - **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 contribute to facial asymmetry over time. - **Severe crowding,** where there's insufficient space for permanent teeth to erupt, which may cause teeth to emerge in abnormal positions or become impacted. - **Significant overjet,** where the upper front teeth protrude markedly, increasing the risk of trauma and sometimes pointing to an underlying skeletal jaw discrepancy. - **Early loss of baby teeth** through decay or trauma, which can allow

adjacent teeth to drift and result in lost space for permanent successors. - **Thumb or finger sucking beyond age 5–6,** since prolonged digit habits can alter jaw shape and tooth position in ways that become progressively harder to address. - **Mouth breathing and airway concerns,** which are associated with specific jaw growth patterns that respond better to intervention during active growth. - **Tooth impaction,** particularly canine teeth travelling on an abnormal eruption path, which may be redirected with timely space management. - **Narrow upper jaw,** where a constricted palate contributes to crowding, crossbite, or bite problems. - **Delayed eruption or retained baby teeth,** which may indicate underlying concerns with permanent tooth development.

What to expect: step by step

Orthodontic assessment

The assessment begins with a thorough clinical examination covering tooth eruption, bite, jaw relationship, and facial profile. Radiographs are reviewed carefully — typically an OPG to visualise all developing teeth, and a lateral cephalogram to assess jaw position. Digital photographs and, in some cases, an intraoral scan may also be taken. Your specialist orthodontist will walk you through the findings directly and explain whether active treatment is recommended or whether a structured monitoring programme makes more sense at this point.

Monitoring without treatment

In many cases, the most appropriate recommendation is active surveillance: scheduled review appointments, typically every six to twelve months, to monitor tooth eruption and jaw development without starting active treatment. This isn't a default position or a deferral — it's a considered clinical decision made when waiting is likely to produce equivalent or better outcomes than treating now.

Treatment planning for Phase 1

When early intervention is warranted, a treatment plan is built around the specific problem being addressed. This may involve one or more of the following:

- **Palatal expander (rapid maxillary expansion)** — a fixed or removable appliance that gradually widens the upper jaw, used for narrow palates contributing to posterior crossbite or severe crowding. This works best during childhood, when the mid-palatal suture remains unfused and responsive to expansion forces. - **Space maintainers** — passive appliances that prevent neighbouring teeth from drifting into spaces left by the premature loss of baby teeth. - **Partial braces** — brackets placed on a limited number of teeth to address specific localised problems, such as a front-tooth crossbite. - **Functional appliances** — removable or fixed devices designed to modify jaw position and influence growth in children where a significant overbite or underbite relates to a jaw size discrepancy. - **Clear aligners for children** — clear aligner systems also offer children's products suited to certain early-phase indications.

Phase 2 treatment

Early intervention doesn't remove the need for a full course of orthodontic treatment later. Most children who go through Phase 1 will still proceed to Phase 2 — typically full braces or aligners — once all permanent teeth have come through. Phase 1 may reduce the complexity or duration of that second phase, and in some cases prevents outcomes that would otherwise require surgical management.

Recovery and aftercare

The adjustment experience varies depending on the appliance:

- **Palatal expanders** require an adaptation period of one to two weeks. Children generally adjust well. A parent uses an activation key to turn the expander by the prescribed amount daily or every few days. Mild pressure or discomfort during activation is a normal part of the process. - **Partial braces** produce a similar experience to full braces — mild soreness for a few days after initial placement and following each adjustment appointment. - **Functional appliances** tend to be bulkier, and may take one to two weeks to adapt to, particularly with respect to speech.

Oral hygiene matters throughout early intervention, regardless of which appliance is in use. Children will need supervised brushing and help cleaning around appliances. Regular dental check-ups with the child's general dentist should continue uninterrupted during orthodontic treatment.

Once early intervention is complete, retainers or passive holding appliances are typically provided to maintain the correction achieved while the child continues to grow toward Phase 2.

Why see a specialist orthodontist?

Deciding whether and when to treat a child orthodontically requires a thorough understanding of growth and development — not simply an assessment of tooth position in isolation. A specialist orthodontist has completed three or more additional years of postgraduate training specifically in orthodontics, covering craniofacial growth, tooth eruption patterns, and how skeletal and dental changes interact across development.

General dentists are well placed to spot obvious orthodontic concerns and refer appropriately, and their role in early identification is genuinely valuable. But the diagnosis, treatment planning, and clinical management of interceptive orthodontic treatment should rest with a registered specialist. This distinction carries particular weight in early intervention, where an incorrect decision — to treat or not to treat, at the right or wrong time — can have lasting consequences for a child's development.

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

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). Experienced in treating children and adults across the full range of orthodontic presentations. - **Dr Andrea Phatouros** — BDSc (WA), MDSc Orth (WA), FRACDS. Involved in postgraduate orthodontic teaching at both undergraduate and postgraduate levels. - **Dr Joshua Ch'ng** — BDSc (Melb), FRACDS, D.Clin.Dent (Melb). Specialist training at the University of Melbourne, with research interests 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. Parents are encouraged to verify specialist registration independently at [AHPRA](https://www.ahpra.gov.au).

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

Related treatments

- [Traditional Metal Braces](/procedures/orthodontics/traditional-metal-braces/) — Phase 2 fixed appliance treatment following early intervention - [Invisalign](/procedures/orthodontics/invisalign-clear-aligner-treatment/) — clear aligner options including children's early-phase presentations - [Surgical Orthodontics](/procedures/orthodontics/surgical-orthodontics-orthognathic-treatment/) — for skeletal problems that cannot be resolved by orthodontics alone once growth is complete - [Paediatric First Dental Visit](/procedures/paediatric-dentistry/your-child-s-first-dental-visit/) — information on specialist paediatric dental care and its overlap with orthodontic development

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