

Children's Orthodontics at Smile Solutions: Early Intervention, Phase 1 Treatment, and the Right Age for a First Assessment

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Most parents associate orthodontics with the teenage years — a rite of passage involving metal braces and school photos. But for a significant number of children, waiting until all the adult teeth have erupted means missing a narrow biological window during which the growing jaws can be guided, habits corrected, and developing malocclusions intercepted before they become structurally fixed. At Smile Solutions Melbourne CBD, children's orthodontics is not simply a scaled-down version of adult treatment. It is a distinct clinical discipline, delivered by registered specialist orthodontists, that leverages the unique plasticity of the growing face to achieve outcomes that are simply not possible once skeletal development is complete.

This article explains what early interceptive orthodontics (Phase 1) involves, which clinical signs parents should watch for, why an assessment between ages 7 and 10 is clinically meaningful, and how Smile Solutions' specialist team, child-friendly environment, and in-house technology support the best possible outcomes for young patients.

What Is Early Interceptive Orthodontics (Phase 1 Treatment)?

Early orthodontic intervention, often referred to as interceptive treatment, is typically initiated during the early mixed dentition phase and addresses skeletal or dental discrepancies, such as Class II or III malocclusions, posterior crossbites, or significant arch length discrepancies. The term "Phase 1" distinguishes this early stage of treatment — usually undertaken between ages 6 and 10 — from "Phase 2," the comprehensive orthodontic treatment that may follow once most or all permanent teeth have erupted.

Early orthodontic intervention aims to identify and correct dental and skeletal abnormalities during craniofacial growth, preventing the progression of complex orthodontic problems and reducing the need for extensive treatment later in adolescence or adulthood.

Critically, Phase 1 treatment is not appropriate for every child. Only about 20–30% of children require interceptive orthodontics, based on individual assessments. The purpose of an early evaluation is not to start treatment prematurely, but to identify the subset of children for whom early intervention will

meaningfully change the trajectory of their dental development — and to monitor the rest.

What Phase 1 Treatment Is Not

An early assessment is not a commitment to immediate treatment. An early evaluation doesn't automatically mean early treatment. Most children seen at age 7 don't need any intervention at all. At Smile Solutions, the specialist orthodontist's role at a first assessment is to determine one of three outcomes: begin Phase 1 treatment now, establish a monitoring schedule and reassess in 6–12 months, or confirm that no intervention is needed and schedule a Phase 2 consultation at an appropriate future age.

The Right Age for a First Orthodontic Assessment: Why Ages 7–10 Matter

The American Association of Orthodontists recommends that all children be screened by an orthodontist at age 7. By age 7, a child has enough permanent teeth that an orthodontist can spot a problem before it becomes a bigger problem.

The best age for a child's first orthodontic screening is 7. At this age, the first permanent molars have erupted and enough adult teeth are visible for an orthodontist to spot bite issues, jaw growth concerns, and crowding patterns early.

This recommendation is not arbitrary. The first permanent molars — the "six-year molars" — establish the back bite relationship, and the upper and lower front permanent incisors are beginning to erupt. This combination gives a specialist orthodontist a genuine diagnostic window: an early orthodontic evaluation is a screening where an orthodontist assesses the child's dental development, including jaw growth, bite alignment, tooth spacing, and the position of emerging permanent teeth.

For Australian families, the equivalent guidance from the Australian Society of Orthodontists aligns with this international consensus. At Smile Solutions, the specialist team recommends a first assessment for most children around age 7–8, though certain clinical signs (detailed below) warrant an earlier visit regardless of age.

The Biological Case for Early Intervention

A child's jaw is not fully formed. It is actively growing and highly responsive to guidance. This is the single biggest advantage of early treatment.

In the case of conditions such as posterior crossbites and Class III malocclusion, evidence-based literature shows that a relatively short phase of interceptive treatment with simple appliances can normalize abnormal growth, and that the result of this treatment approach will remain stable over time. If jaw problems are left until the growth window closes, typically by the mid-teen years, the only options left may be surgery or prolonged treatment that still cannot fully correct the underlying structure.

This is the core clinical argument for early evaluation: not that every child needs early treatment, but that for those who do, the window of opportunity is genuinely time-limited.

Clinical Signs Parents Should Watch For

A specialist orthodontist will conduct a comprehensive assessment regardless of whether parents have noticed anything concerning. However, certain observable signs at home warrant an earlier appointment — ideally before the recommended age-7 milestone.

1. Posterior Crossbite

A crossbite occurs when one or more upper teeth sit inside the lower teeth when biting. Posterior crossbite and anterior crossbite do not have a spontaneous correction and should be treated with maxillary expansion as early as possible, after an accurate diagnosis.

The posterior crossbite is one of the most frequent malocclusions in orthodontics, and its possible etiologies include prolonged retention or loss at an early age of deciduous teeth, crowding, cleft palate, genetic factors, tooth-size arch-length discrepancies, abnormalities in tooth morphology, eruption sequence, thumb sucking habits, and mouth breathing during critical growth periods.

Early correction using palatal expansion appliances is well supported by evidence. A recent high-standard meta-analysis demonstrated that orthodontic treatment with Quad-Helix, Hyrax, and expansion removable plates is effective for correcting posterior crossbite in children. The mid-palatal suture in young children is still cartilaginous and highly responsive to expansion forces — a biological advantage that is progressively lost as the child approaches adolescence and the suture begins to ossify.

2. Mouth Breathing

Persistent mouth breathing — particularly during sleep — is one of the most consequential yet underrecognised signs that a child needs an early orthodontic assessment. The evidence analyzed suggests that mouth breathing is consistently associated with craniofacial and dentofacial alterations in the pediatric population, including vertical growth patterns, maxillary narrowing, and malocclusions.

Mouth breathers demonstrate considerable backward and downward rotation of the mandible, increased overjet, increase in the mandible plane angle, a higher palatal plane, and narrowing of both upper and lower arches at the level of canines and first molars compared to nasal breathers. The prevalence of posterior crossbite was significantly more frequent in the mouth breathers group (49%) than nose breathers (26%).

Results indicate a strong link between oral breathing and dentofacial changes such as adenoid facies, Class II malocclusion, posterior crossbite, and anterior open bite.

Timely identification of this breathing pattern allows for the implementation of interdisciplinary interventions that include orthodontics, otolaryngology, and myofunctional therapy, with the aim of preventing more severe structural alterations and improving the stability of treatments. At Smile Solutions, the multidisciplinary nature of the practice — with ENT specialists, orthodontists, and other clinical specialists accessible under one roof — makes this collaborative management approach genuinely achievable.

3. Thumb-Sucking Past Age Four

Thumb-sucking is a normal infant reflex. The clinical concern arises when the habit persists into the years when permanent teeth are beginning to erupt. In general, malocclusion is more likely to resolve spontaneously if the habit ceases before the eruption of permanent dentition, typically by age 6.

Dental research associates extended sucking past age four with protruding front teeth, spaces between teeth, and alterations in the palate.

Thumb-sucking can result in malocclusion, or improper alignment of teeth when biting down. Most commonly, this misalignment is seen in two ways: an anterior open bite and a posterior crossbite. An anterior open bite means that the upper and lower front teeth do not touch each other when you bite down. A posterior crossbite means that the upper jaw is too narrow for the lower jaw, resulting in the upper teeth not fitting properly with the lower teeth. Usually, if thumb-sucking is discontinued early, the anterior open bite will correct itself. The posterior crossbite, on the other hand, will not self-correct and will inevitably require orthodontic treatment, such as a palatal expander and braces.

4. Asymmetric Jaw Development

If a child's chin appears to deviate to one side, if one side of the jaw appears fuller than the other, or if a parent notices that the child consistently chews on one side only, these may be signs of asymmetric jaw development. Asymmetry in growing children can reflect underlying skeletal discrepancies — including unilateral crossbites that cause the mandible to shift laterally on closure — that are significantly more manageable when intercepted early. An untreated unilateral crossbite can cause the lower jaw to habituate to a shifted closure pattern, leading to structural facial asymmetry over time.

5. Early or Late Loss of Baby Teeth

Baby teeth serve as natural space maintainers for the incoming permanent teeth. Premature loss (before the permanent successor is ready to erupt) can cause adjacent teeth to drift and reduce the available space. Conversely, retained baby teeth that do not fall out at the expected time can deflect permanent teeth from their intended eruption path. Either scenario warrants an assessment.

6. Crowding or Spacing Visible in the Primary Dentition

Some degree of spacing in the primary (baby) dentition is normal and actually desirable — it provides "leeway space" for the larger permanent teeth. However, severe crowding in the primary dentition, particularly combined with a narrow arch form, may indicate that the permanent dentition will not have adequate space without intervention.

What Does a Phase 1 Assessment at Smile Solutions Involve?

At Smile Solutions Melbourne CBD, a child's first orthodontic assessment is conducted by a registered specialist orthodontist — not a general dentist with an interest in orthodontics (see our guide on **What Is a Specialist Orthodontist? How Smile Solutions' Registered Orthodontists Differ from General Dentists** for a full explanation of this distinction and why it matters).

The assessment typically includes:

| Component | Purpose | |---|---| | Clinical examination | Assess tooth positions, bite relationship, arch width, and jaw symmetry | | Dental and facial photographs | Baseline documentation for monitoring and treatment planning | | Digital X-rays (OPG and lateral cephalogram, where indicated) | Assess root development, eruption sequence, jaw relationship | | iTero digital scan (where appropriate) | 3D model of the dentition without physical impressions | | Habit and airway screening | Identify mouth breathing, tongue thrust, thumb-sucking | | Growth assessment | Estimate skeletal maturity and optimal treatment timing |

The outcome of the assessment is one of three recommendations: active Phase 1 treatment, active monitoring with scheduled review appointments, or no action required. In every case, parents receive a clear explanation of the findings and the rationale for the recommendation.

Phase 1 Treatment Options at Smile Solutions

When early intervention is clinically indicated, the specialist orthodontist at Smile Solutions selects from a range of appliances depending on the specific problem being addressed:

- ****Palatal expanders (rapid maxillary expansion):**** Used to widen a narrow upper arch, correct posterior crossbites, and create space for erupting permanent teeth. The rapid maxillary expander not only addresses the underlying skeletal discrepancy but also improves nasal airflow and overall arch coordination.

- ****Functional appliances:**** Used to influence jaw growth relationships in growing children, particularly for Class II discrepancies (where the lower jaw is positioned behind the upper jaw). - ****Space**

maintainers:** Fixed or removable appliances that hold space following premature loss of a baby tooth.

- **Habit-breaking appliances:** Fixed or removable appliances that interrupt thumb-sucking or tongue-thrust habits.
- **Partial fixed braces:** In some Phase 1 cases, a limited number of brackets on specific teeth may be used to correct localised problems such as an anterior crossbite (a single upper front tooth biting behind a lower tooth).

Empower Self-Ligating Brackets at Smile Solutions

Where fixed braces are indicated — whether in Phase 1 or Phase 2 treatment — Smile Solutions uses the **Empower self-ligating bracket system**. Unlike conventional brackets that use elastic ties to hold the archwire, Empower brackets use an integrated clip mechanism that reduces friction, allows for lighter forces, and can shorten overall treatment time. For children, the reduced friction and lower force levels translate to greater comfort throughout treatment. For a comprehensive comparison of all bracket and appliance systems available at Smile Solutions, see our guide on **The Full Spectrum of Orthodontic Treatments Available at Smile Solutions Melbourne CBD**.

What Happens Between Phase 1 and Phase 2?

Following Phase 1 treatment, there is typically a "resting phase" during which the remaining permanent teeth erupt and the child is monitored at regular intervals — usually every 6 to 12 months. This is not a period of inactivity; it is active surveillance to ensure the corrections achieved in Phase 1 are being maintained and to plan the timing and scope of Phase 2 treatment if it is needed.

Early short-term interceptive orthodontic treatment with simple appliances, in the deciduous or early mixed dentition phase, can efficiently correct certain malocclusions and help to either reduce the complexity or even avoid the necessity of complex and expensive procedures during puberty.

Not every child who undergoes Phase 1 treatment will need Phase 2. Where Phase 2 is required, the work completed in Phase 1 typically means a shorter, simpler treatment course — often reducing the time spent in full braces during the adolescent years.

Sport Mouthguards During Orthodontic Treatment

Children undergoing orthodontic treatment — whether with fixed appliances or removable devices — who participate in contact or collision sports require a properly fitted mouthguard. Standard over-the-counter mouthguards do not fit reliably over brackets or expanders and provide inadequate protection. At Smile Solutions, custom-fitted sports mouthguards are fabricated to accommodate the specific appliance configuration of each child patient, providing effective protection for both the teeth and the orthodontic appliance during sport. This is particularly relevant for children in Phase 1 treatment with palatal expanders or partial fixed appliances, where an ill-fitting mouthguard can dislodge or damage the appliance.

The Evidence Base: What the Research Actually Shows

It is important to be clinically honest with parents about what early orthodontic treatment can and cannot guarantee. Although the American Association of Orthodontists recommends an initial screening by age 7, evidence supporting routine early treatment remains limited. Excessive use of early orthodontics may increase treatment duration, costs, and patient fatigue or loss of motivation without long-term benefit if patient selection is inappropriate.

The key phrase is **patient selection**. The evidence strongly supports early intervention for specific, clearly indicated conditions:

- **Posterior crossbites:** Early expansion is well evidenced and produces stable results. - **Severe skeletal Class III (underbite):** Early (interceptive) treatment leverages growth potential to correct developing anomalies and is often indicated for posterior crossbites, skeletal Class III malocclusions, or pronounced arch length discrepancies.

- **Trauma risk from increased overjet:** An increased overjet (>5 mm) in children aged 7 to 14 is associated with more than double the risk of dental trauma, reinforcing the argument for early intervention in selected cases.

- **Interceptive treatment outcomes in mixed dentition:** Results of a retrospective analysis of 150 children with mixed dentition who received interceptive orthodontic treatment indicate significant improvements in dental alignment and occlusion. The average reduction in overjet was 3.5 mm, and the overbite correction averaged 2.1 mm.

For Class II malocclusions without significant overjet or trauma risk, the evidence for routine early treatment is less compelling, and a specialist orthodontist at Smile Solutions will weigh the clinical picture carefully before recommending Phase 1 intervention.

Key Takeaways

- **An orthodontic assessment between ages 7 and 10 is clinically meaningful** because the first permanent molars have erupted, establishing the back bite relationship, and the jaws are still actively growing and responsive to guidance. - **Phase 1 (early interceptive) treatment is not for every child.** Approximately 20–30% of children assessed early will benefit from active intervention; the remainder are monitored or cleared. - **Specific clinical signs** — including posterior crossbite, persistent mouth breathing, thumb-sucking past age four, and visible jaw asymmetry — warrant an earlier assessment rather than waiting for the standard age-7 milestone. - **Conditions like posterior crossbite do not self-correct** and are significantly more manageable with palatal expansion during the mixed dentition phase, before the mid-palatal suture begins to fuse in adolescence. - **At Smile Solutions, all children's orthodontic assessments are conducted by registered specialist orthodontists**, not general dentists — ensuring that the diagnostic threshold, treatment planning, and appliance selection reflect specialist-level training and clinical experience.

Conclusion

The decision to have a child assessed by a specialist orthodontist is not a commitment to treatment — it is a commitment to information. For the majority of children, an early assessment will confirm that development is on track and provide parents with the reassurance of a specialist opinion. For the minority who do have a developing problem, that assessment can mean the difference between a straightforward Phase 1 intervention and a far more complex treatment course — or, in some cases, jaw surgery — years later.

At Smile Solutions Melbourne CBD, children's orthodontics is delivered within a purpose-designed, child-friendly environment by registered specialist orthodontists who understand both the clinical science and the very human experience of being a child patient. The practice's in-house technology — including iTero digital scanning and digital radiography — ensures that assessments are thorough, accurate, and free of the discomfort associated with traditional impression materials (see our guide on ***Orthodontic Technology at Smile Solutions: iTero Scanning, Dental Monitoring, and the In-House Laboratory Advantage***).

If your child is approaching age seven, or if you have noticed any of the clinical signs described in this article, a specialist orthodontic assessment at Smile Solutions is the logical next step. For families considering the financial dimension of children's orthodontic care, including Child Dental Benefits

Schedule eligibility, see our guide on *Orthodontic Treatment Costs in Melbourne: Pricing, Health Fund Rebates, and Payment Plans at Smile Solutions*. And for parents of adolescents wondering whether Invisalign is appropriate for younger patients, our article on *Invisalign Teen vs Invisalign for Adults* addresses the specific clinical and compliance considerations for this age group in detail.

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