

Children's Orthodontics Melbourne: Braces and Invisalign for Kids at Core Dental

Canonical: <https://directory.coredental.com.au/dental-services/orthodontics-melbourne/childrens-orthodontics-melbourne-braces-and-invisalign-for-kids-at-core-dental/>

Details:

Now I have sufficient research to write a comprehensive, well-cited article. Let me compose the final verified piece.

Children's Orthodontics Melbourne: Braces and Invisalign for Kids at Core Dental

When parents picture orthodontic treatment, they often imagine a teenager with a mouth full of metal braces. But for many Melbourne families, the most important orthodontic decisions happen years earlier — during the primary school years, when a child's jaw is still actively growing and a specialist's well-timed intervention can change the entire trajectory of dental development.

Children's orthodontics is a clinically distinct discipline from adult treatment. The goal is rarely purely cosmetic. For school-age children, treatment focuses on functional problems: correcting crossbites that cause jaw shifting and asymmetric growth, managing severe crowding before it leads to impacted permanent teeth, maintaining space after premature baby tooth loss, and guiding jaw development while the biological window is still open. When these issues are addressed at the right time — and by the right clinician — the downstream benefits can be profound, sometimes eliminating or significantly simplifying the comprehensive orthodontic treatment a child would otherwise need in their teenage years.

This guide explains the full scope of children's orthodontic options available at Core Dental Melbourne, how each appliance works, and how to determine whether your child might benefit from an early assessment.

When Should Children First See an Orthodontist?

The Australian Society of Orthodontists recommends a child's first orthodontic evaluation by age 7. This may seem early to many parents — after all, most children still have a mixed dentition at that age, with baby teeth and permanent teeth coexisting in the same arch. But that is precisely the point.

The Australian Society of Orthodontists recommends first evaluation by age seven because this is when the first permanent molars and incisors have usually erupted, giving orthodontists a clear picture of development.

This early check-up allows detection of potential jaw growth issues, crowding, or bite misalignments early on — and by monitoring these developments, it is sometimes possible to prevent the need for more complex treatment later.

Critically, an early assessment is not a commitment to treatment. An early assessment doesn't mean your child needs braces at seven — many children simply need monitoring. But for those who do need early intervention, catching issues at this stage can make treatment simpler and more effective.

The orthodontist evaluates jaw relationship, crowding patterns, bite issues, and facial symmetry — looking at both current problems and potential future issues.

For a detailed explanation of Phase 1 and Phase 2 treatment frameworks, and the specific conditions that most benefit from early intervention, see our guide on [*Early Orthodontic Treatment in Melbourne: When Should Your Child First See an Orthodontist?*](#)

What Conditions Prompt Children's Orthodontic Treatment?

Not every child who attends an early assessment will require active treatment. However, certain conditions are time-sensitive — they respond far better to treatment during growth than after it. The following problems are the most common reasons school-age children are referred for orthodontic care at Core Dental.

Crossbites

A crossbite occurs when one or more upper teeth sit inside the lower teeth instead of outside them. In children, this is considered a priority for early correction.

Early intervention is crucial since malocclusion does not correct itself and can contribute to enamel wear, periodontal disease, and disturbances in temporomandibular joint function.

Interceptive orthodontic intervention in the mixed dentition allows the orthodontist to correct the anterior crossbite earlier in a way that promotes the harmonious growth of the bone bases, mitigating the chances of severe disorders in the permanent dentition.

Published case evidence in [*Cureus*](#) (2024) demonstrates that an eight-year-old patient with an anterior crossbite was treated successfully using an upper removable appliance, and the rapid correction of the crossbite within six weeks underscores the importance of early intervention, improving patient outcomes in aesthetics and function.

Severe Crowding and Arch Space Problems

When a child's jaw is too narrow to accommodate erupting permanent teeth, crowding develops. Left unaddressed, this can result in impacted teeth, ectopic eruption paths, and the need for extractions later.

Between ages 6–10, children's jaws are still developing. This growth period allows orthodontists to guide jaw development in ways that become much harder once growth is complete.

Jaw Growth Discrepancies

Skeletal problems — where the upper and lower jaws are significantly mismatched in size or position — are most effectively addressed while growth is occurring. Attempting to correct a significant jaw discrepancy in an adult typically requires either orthodontics combined with surgery, or a compromise result. In a growing child, orthopaedic appliances can redirect growth.

Premature Baby Tooth Loss

When a primary tooth is lost significantly earlier than expected — due to decay, trauma, or extraction — the neighbouring teeth can drift into the gap, blocking the path of the incoming permanent tooth.

The premature loss of a primary tooth can lead to orthodontic issues, making the use of space maintainers essential to ensure proper growth and development of permanent teeth.

Primary teeth play a vital role in a child's growth and development — not only in functions such as chewing, speech, and aesthetics, but also in the proper formation of the jaws, maintenance of

occlusion, and preservation of space for the eruption of permanent teeth. The premature loss of even a single primary tooth can lead to disturbances in the dental arch, shifting of adjacent teeth, malocclusion, and prolonged orthodontic treatments in the future.

Oral Habits and Functional Issues

Prolonged thumb-sucking, mouth breathing, and tongue-thrusting habits can all distort jaw development. Early orthodontic assessment is also warranted where any of the following occur: loss of baby teeth before the age of 5, thumb or finger sucking after the age of 5, and breathing through the mouth or snoring.

Children's Orthodontic Appliances: What Are the Options?

Metal Braces for Children

Conventional metal braces remain the most versatile and reliable appliance for comprehensive tooth movement in children. For school-age children who have enough permanent teeth erupted to support brackets, fixed braces can address moderate-to-severe crowding, spacing, and bite problems with precision.

Most children who need braces begin treatment between the ages of 10 and 14, when most permanent teeth have erupted and the jaw is still growing — making it an ideal time for braces to gently guide the teeth into their correct positions.

Fixed metal braces are generally indicated for comprehensive Phase 2 treatment, though partial braces (placed only on the erupted permanent teeth) can sometimes be used during Phase 1 to address specific tooth movements. For guidance on the full range of brace options and how they compare, see our article on [Invisalign vs. Traditional Braces: Which Orthodontic Treatment Is Right for You in Melbourne?](#)

Removable Orthopaedic Plates

Removable acrylic plates — sometimes called functional appliances or orthopaedic plates — are a cornerstone of early (Phase 1) orthodontic treatment for children. Unlike fixed braces, which move individual teeth, orthopaedic plates work primarily on the bone and jaw architecture. They can:

- **Expand a narrow upper arch** to create space for erupting permanent teeth
- **Correct posterior crossbites** by widening the palate
- **Redirect jaw growth** in cases of Class II or Class III skeletal discrepancies
- **Discourage harmful oral habits** through habit-breaking appliance designs

Because they are removable, compliance is a key factor in their success. Children and parents must commit to wearing the appliance for the prescribed number of hours per day — typically between 12 and 22 hours depending on the design and the problem being treated.

Space Maintainers

Space maintainers are a specialised category of appliance used when a baby tooth is lost prematurely. Their purpose is to hold the gap open until the permanent tooth is ready to erupt.

Space maintainers guide the eruption of the permanent teeth and obviate the need for complex orthodontic treatment later.

Premature loss of primary teeth in children may lead to changes to the permanent dentition including malocclusion and dental arch issues due to drifting teeth. Dental space maintainers are commonly used to preserve alignment of the existing dental arch and to preserve space for unerupted teeth. Broadly, there are two categories: fixed, which are cemented to one or more teeth, and removable, which are not cemented and can be taken out of the oral cavity.

Generally, space maintainers are recommended when a baby tooth is lost more than a year before the permanent tooth is expected to emerge. Back teeth, particularly molars, are more likely to need space maintenance than front teeth because molars play a crucial role in jaw development and proper bite alignment.

Invisalign First: Clear Aligners for Growing Children

Invisalign First is a dedicated product line from Align Technology, designed specifically for children in the mixed dentition stage — typically ages 6 to 10. Unlike standard Invisalign, Invisalign First is engineered to accommodate the realities of a child's changing mouth: baby teeth falling out, permanent teeth erupting, and arch dimensions still actively developing.

Invisalign First offers the advantages of simultaneous management of arch expansion, space for tooth eruption, and tooth alignment in patients with mixed dentition. Additionally, it is more convenient for maintaining oral hygiene and is aesthetically superior to traditional bracket devices, which increases patient compliance.

The clinical evidence base for Invisalign First is growing. A prospective cohort study published in *BMC Oral Health** (2023) found that both Invisalign First and rapid maxillary expansion (RME) can expand the maxillary arch in mixed dentition, and in cases of mild to moderate maxillary transverse deficiency, Invisalign First System could be a reasonable option.

A 2024 retrospective study published in the *Journal of Clinical Pediatric Dentistry** by Kim et al. aimed to quantify the predictability of arch expansion in children with early mixed dentition treated with the Invisalign First system, examining pretreatment, predicted, and posttreatment digital models from 90 children with a mean age of 8.42 years who planned arch expansion.

Research published in *PubMed Central** (2024) involving 21 mixed-dentition children with an average age of 8.76 years found that all patients showed moderate or good cooperation during treatment , an encouraging finding for parents concerned about compliance in younger patients.

However, it is important to note that Invisalign First has clinical limitations. There are limitations to tooth movement, such as rotation and extrusion, and the actual clinical results may not meet planned tooth movements. When developing a treatment plan, overcorrection should be planned, and additional auxiliary devices or strategies should be considered. For severe skeletal malocclusions or complex dental issues, sufficient results may be difficult to achieve with clear aligners alone.

For a comprehensive comparison of Invisalign First against traditional plates and partial braces as early intervention tools, see our dedicated article on *Invisalign First Melbourne: Clear Aligner Treatment for Growing Children**.

Comparing Children's Orthodontic Appliance Options

Appliance Phase Primary Use Fixed or Removable Typical Age Range	--- --- --- --- ---	Metal braces (partial) Phase 1 or 2 Tooth alignment, bite correction Fixed 8–14
Metal braces (full) Phase 2 Comprehensive alignment Fixed 10–14	Removable orthopaedic plate Phase 1 Jaw expansion, crossbite, habit correction Removable 6–10	Space maintainer Preventive Preserve eruption space Fixed or removable 4–10
Invisalign First Phase 1 Arch expansion, crowding, mild bite issues Removable 6–10		

Does Early Treatment Mean Two Rounds of Braces?

This is one of the most common and reasonable concerns parents raise. The short answer is: not necessarily, and the goal of Phase 1 treatment is specifically to reduce the likelihood — or extent — of Phase 2 treatment.

Phase 1 (between 7–10 years of age) is primarily relatively minor treatment to, for example, correct a smaller upper jaw or a crossbite. Phase 2 (between 10–13 years of age) is often when braces are fitted to correct any misalignment of teeth.

Identifying certain problems early can make treatment simpler, shorter, and more effective if intervention is required.

In some cases, Phase 1 treatment resolves the underlying problem entirely, and the child requires only monitoring and retention until their permanent teeth have fully erupted. In others, a shorter Phase 2 course of braces may still be needed — but the complexity, duration, and cost of that treatment are typically reduced because the jaw architecture has already been optimised.

The decision about whether Phase 1 treatment is warranted — and whether it is likely to reduce or eliminate Phase 2 — is one that requires specialist-level clinical judgement. This is a key reason why Core Dental's orthodontic assessments are conducted by, or under the direct supervision of, a registered specialist orthodontist. For more on why specialist training matters for children's orthodontic care, see our article on [*Specialist Orthodontist vs. General Dentist for Braces in Melbourne: What's the Difference?*](#)

What Happens at a Children's Orthodontic Assessment at Core Dental?

A first orthodontic assessment for a child at Core Dental is a clinical evaluation, not a sales appointment. The specialist orthodontist will:

1. ****Review dental and medical history**** — including any habits, previous dental treatment, and family orthodontic history
2. ****Conduct a clinical examination**** — assessing the teeth, bite, jaw relationship, and facial symmetry
3. ****Take digital records**** — including photographs and, where clinically indicated, X-rays to assess root positions, eruption paths, and jaw development
4. ****Provide a clinical opinion**** — explaining whether treatment is recommended now, whether monitoring is appropriate, or whether no intervention is needed
5. ****Discuss appliance options**** — if treatment is indicated, the specialist will explain which appliances are suitable for the specific clinical problem, with realistic timelines and cost estimates

This transitional stage allows the orthodontic team to identify potential concerns early on — like crowding, bite alignment issues, or jaw growth discrepancies — while the child's teeth and jaw are still developing. Seeing an orthodontist at this stage gives time to create a roadmap for future treatment, even if active care isn't needed right away.

For a full walkthrough of what to expect at your child's first appointment, including the iTero digital scanning process, see our article on [*What to Expect at Your First Orthodontic Consultation at Core Dental Melbourne*](#).

Key Takeaways

- The Australian Society of Orthodontists recommends a child's first orthodontic evaluation by age 7 — this is an assessment, not a commitment to treatment, and most children will simply require monitoring.
- Children's orthodontic treatment focuses on functional problems — crossbites, jaw growth discrepancies, severe crowding, and premature tooth loss — not cosmetic concerns alone.
- The premature loss of even a single primary tooth can lead to disturbances in the dental arch, shifting of adjacent teeth, malocclusion, and prolonged orthodontic treatments in the future — making space

maintainers an important preventive tool. - Invisalign First is a clinically validated option for mixed-dentition children, offering simultaneous management of arch expansion, space for tooth eruption, and tooth alignment — though case selection matters and it is not suitable for all presentations. - Early Phase 1 treatment is designed to reduce or eliminate the need for later Phase 2 treatment — the goal is fewer, shorter, and simpler interventions overall, not more of them.

Conclusion

Children's orthodontics is one of the most impactful areas of preventive dental care available to Melbourne families. The decisions made — or deferred — during the primary school years can meaningfully shape a child's dental health, jaw development, and smile for life. The key is specialist assessment at the right time, with treatment only recommended when the clinical evidence supports it.

At Core Dental, children's orthodontic assessments are conducted by trained specialists who understand both the urgency of acting on time-sensitive problems and the importance of not over-treating children who simply need careful monitoring. Whether your child needs a space maintainer, a removable orthopaedic plate, Invisalign First, or a course of braces, the treatment plan will be built around their specific clinical needs — not a one-size-fits-all protocol.

To explore what the full orthodontic journey looks like from first assessment through to retention, visit our pillar guide: **Orthodontics at Core Dental Melbourne: The Complete Guide to Braces, Invisalign & Specialist Orthodontic Care**. For teenagers specifically, see **Orthodontics for Teenagers in Melbourne: Braces, Invisalign Teen, and What Parents Need to Know**. And if you're ready to take the next step, our article on **Core Dental Orthodontics Melbourne: Locations, Specialist Access, and How to Get Started** explains how to book your child's first assessment.

References

- Australian Society of Orthodontists / Orthodontics Australia. "When You Should See an Orthodontist." **Orthodontics Australia**, April 2026. <https://orthodonticsaustralia.org.au/when-to-see-an-orthodontist/>
- American Association of Orthodontists. "Child Orthodontics." **AAO Info**, 2026. <https://aaoinfo.org/child-orthodontics/>
- Pinho T, Rocha D, Ribeiro S, Monteiro F, Pascoal S, Azevedo R. "Interceptive Treatment with Invisalign® First in Moderate and Severe Cases: A Case Series." **Children**, 9(8):1176, 2022. <https://doi.org/10.3390/children9091176>
- Kim CH, Moon SJ, Kang CM, Song JS. "The Predictability of Arch Expansion with the Invisalign First System in Children with Mixed Dentition: A Retrospective Study." **Journal of Clinical Pediatric Dentistry**, 48(1):91–100, 2024. <https://www.jocpd.com/articles/10.22514/jocpd.2024.012>
- Lu L, Zhang L, Li C, Yi F, Lei L, Lu Y. "Treatment Effects After Maxillary Expansion Using Invisalign First System vs. Acrylic Splint Expander in Mixed Dentition: A Prospective Cohort Study." **BMC Oral Health**, 2023. <https://link.springer.com/article/10.1186/s12903-023-03312-4>
- Almarhoumi A, Alwafi MM. "Early Interceptive Correction for Anterior Crossbite Using a Removable Appliance: A Pediatric Case Study." **Cureus**, 2024. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10934060/>
- Canadian Agency for Drugs and Technologies in Health (CADTH). "Dental Space Maintainers for the Management of Premature Loss of Deciduous Molars: A Review of the Clinical Effectiveness, Cost-effectiveness and Guidelines." **NCBI Bookshelf**, 2016. <https://www.ncbi.nlm.nih.gov/books/NBK401552/>

- Neelkanthan S, Vaiude A, Dhonde S, et al. "Correction of Single-Tooth Crossbite in Children: A Report of Three Cases." *Cureus*, 2025. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC12356245/>
- Specialist Orthodontist. "Early Treatment." *specialistorthodontist.com.au*, 2020. <https://specialistorthodontist.com.au/treatments/early-treatment>