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Lockett v. Ohio, 438 U.S. 586; 98 S.Ct. 2954 (1978)

Zant v. Stephens, 462 U.S. 862; 103 S.Ct. 2733 (1983)

Other Authorities:

C. Slobogin, Mental Illness and the Death Penalty, American Bar Association's Mental and Physical Disability Law Reporter, (July/August 2000)

R.L. Spitzer, J.B. Foreman, and J. Nee, Field Trials for Inter-Rater Diagnostic Reliability, 136 American Journal of Psychiatry 6 815 (1979)

E.F. Torrey, Surviving Schizophrenia (Third Edition, 1995).

A. Tasman, J. Kay and J. Lieberman, Psychiatry: Volume 2, (1997)

J.E. Scott and L.B. Dixon, Assertive Community Treatment and Case Management for Schizophrenia, Schizophrenia Bulletin 21(4) 657 (1995)

E.L. Goldman, Program Reduces Jail Recidivism for Mentally Ill, Clinical Psychiatry News, (December 1996)

H. Steadman, E. Mulvey, J. Monahan, et. al., Violence by People Discharged From Acute Psychiatric Inpatient Facilities And By Others In The Same Neighborhoods, Archives of General Psychiatry, 55:393 (1998).

M. Swartz, J. Swanson, V. Hiday, et. al., Violence and Severe Mental Illness, American Journal of Psychiatry, 155:226 (1998)

Treatment Advocacy Center, Suicide Among Individuals with Schizophrenia and Manic-Depressive Illness, 1 (2001).

R. Stincelli, Suicide By Cop: The Long Road Back, www.suicidebycop.com

F.K. Goodwin and K.R. Jamison, Manic-Depressive Illness (1990)

D.M. Steinwachs, et. al., Family Perspectives on Meeting the Need for Care of Severely Mentally Ill Relatives: A National Survey, Johns Hopkins School of Public Health (1992)

I. Interests of the *Amici*

The National Alliance for the Mentally Ill (NAMI), with more than 200,000 members and 1,300 state and local affiliates, is the nation's leading grassroots organization dedicated exclusively to improving the lives of persons with severe mental illnesses, including schizophrenia, bipolar disorder (manic-depressive illness), major depression, obsessive-compulsive disorder, and severe anxiety disorders. The Georgia Alliance for the Mentally Ill (NAMI-Georgia) is the leading advocacy organization for people with severe mental illnesses in Georgia. Comprised of family members of persons with severe mental illnesses as well as persons with these illnesses themselves, NAMI-Georgia has a membership of 1,200, with 30 affiliates throughout the state.

NAMI and NAMI-Georgia oppose the death penalty for people with severe, biologically based mental illnesses. Our purpose in submitting this brief is to provide the court with information about schizoaffective disorder, Daniel Colwell's diagnosis, and to assist the court in evaluating the impact of this brain disorder on Mr. Colwell's mental state at the time of his crime.

II. Introduction

Daniel Colwell has suffered from a severe mental illness, schizoaffective disorder, for many years. During this time, he has steadily descended into the dark depths of psychosis and extreme suicidal depression. He has been in and out of psychiatric hospitals, has had brushes with the law due to bizarre behaviors that were a direct consequence of his delusional state, and has generally been ill served by the mental health system set up to treat people like him.

Daniel Colwell is not an inherently evil man. He never demonstrated any tendency for violent or criminal behavior before the onset of his illness in his early twenties. Tragically, his brain disorder caused him to kill Mitchell and Judith Bell, unsuspecting and innocent victims of his psychotic state. For this, Mr. Colwell should pay the consequences – removal from society for the rest of his natural life. However, *Amici* strongly assert that executing Daniel Colwell would be cruel and unjust and would compound the

tragedy of this case. Mr. Colwell extreme mental disturbance at the time of his crime should be recognized as a significant mitigator and the death penalty in this case should be commuted to life without parole.

III. Statement of the Case¹

Daniel Colwell, was arrested and charged with murdering Mitchell and Judith Bell outside of a Wal-Mart east of Americus, Georgia on July 22, 1996. Mr. Colwell turned himself in at the Americus police station a few minutes after the murder, confessed to having committed the murders, and stated that he wanted to be executed for his crimes. This was the tragic culmination of a ten year history of severe mental illness marked by increasingly bizarre behaviors, numerous hospitalizations, several incarcerations, and Mr. Colwell's frequently stated preoccupation with ending his own life to escape the torment that had ruined a once promising life.

The Appellant spent a significant portion of the more than two years that passed between the death of the Bell's and his trial in the hospital, pursuant to a Notice of Defendant's Insanity and Incompetence to Stand Trial under O.C.G.A. 17-7-130.² Although Mr. Colwell was found competent to stand trial on April 23, 1999, he remained in the hospital based on the agreement of all parties until his sentencing hearing from September 30 to October 13, 1999.

As Mr. Colwell continued to insist that he wanted to be sentenced to death, he pleaded guilty to all charges the same day he was found competent to stand trial. His attorneys were therefore never able to mount a defense on his behalf. A sentencing hearing was conducted from September 30 to October 13, 1999.³ At that hearing, numerous witnesses took the stand and testified to Mr. Colwell's good character prior to the onset of his severe mental illness and the mitigating effects of his illness. Despite that testimony, the jury returned a verdict of death.⁴ Mr. Colwell's case is now before this Court for review pursuant to O.C.G.A. § 17-10-35.

IV. Argument

A. Daniel Colwell's Severe Mental Illness Is A Significant Factor In Mitigation Of The Death Sentence Imposed In This Case.

¹ Amici additionally incorporate by reference the lengthy factual history contained in the Appellate Brief submitted by the Appellant, Daniel Colwell

² Appellant's Brief, 5.

³ Id. at 2.

⁴ Id.

A death sentence is the ultimate punishment that can be imposed on a criminal defendant. While the Supreme Court of the United States has upheld the death penalty as constitutional under certain circumstances, the Court has also emphasized that this extreme punishment should be imposed only in cases with egregious circumstances, and only when the discretion of juries is limited through clear statutory guidelines. See, e.g., Zant v. Stephens, 462 U.S. 862, 103 S. Ct. 2733 (1983), summarizing why the U.S. Supreme Court upheld the amended Georgia statute in Gregg v. Georgia, 428 U.S. 153, 96 S.Ct 2909 (1976); “(This conclusion rested ... on the fundamental requirement that...an aggravating circumstance must genuinely narrow the class of persons eligible for the death penalty and must reasonably justify the imposition of a more severe sentence on the defendant compared to others found guilty of murder).”

Although Georgia’s death penalty statute does not contain a specific list of mitigating factors for juries to consider, the Supreme Court of the U.S. has clearly established that sentencing bodies may not be prevented from considering “*as a mitigating factor*, any aspect of a defendant’s character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death.” Lockett v. Ohio, 438 U.S. 586; 98 S.Ct. 2954 (1978).

1. As with mental retardation, severe mental illnesses can significantly impair cognition and orientation to reality.

Georgia, along with twelve other states and the District of Columbia, statutorily prohibits the execution of people with mental retardation. Christopher Slobogin, “Mental Illness and the Death Penalty”, 24:4 *Mental and Physical Disability Law Reporter*, 667 (July/August 2000). This reflects the Georgia Legislature’s recognition that conditions that impair the functioning of the brain mitigate against imposition of the

death penalty in capital cases. While severe mental illnesses are different from mental retardation in that they do not necessarily manifest in substandard intelligence, the same considerations that have led legislatures and courts to recognize mental retardation in mitigation of the death penalty apply to severe mental illnesses such as schizophrenia, schizoaffective disorder, and bipolar disorder (manic-depressive illness). Yet, there is no express recognition of these brain disorders as potential mitigators in the Georgia death penalty statute.

In Daniel Colwell's case, there is clear evidence in the record that his severe mental illness significantly impaired his cognition and his orientation to reality. His illness transformed him from a once promising student and athlete to someone who was unable to hold down a job and whose disability was so severe that he was found eligible for federal social security disability benefits.⁵ Even more significantly, his orientation to reality was seriously impaired, as evidenced by his bizarre and erratic behaviors over a ten year span and the frequent assertions of those treating him that he was psychotic, extremely paranoid and delusional. See, generally, Appellant's Brief, pp. 19-73.

One argument that has been raised in support of differentiating between mental retardation and mental illness for purposes of capital punishment is that mental retardation may be easier to identify and diagnose than mental illness. However, this is not a valid justification. Science has made huge strides in diagnosing and treating schizophrenia, bipolar disorder and other severe mental illnesses. While no objective measures such as intelligence tests yet exist to measure schizophrenia and other severe mental illnesses, these brain disorders can today be diagnosed as accurately or more

⁵ Eligibility for Federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits is predicated upon being determined to be too severely disabled to work.

accurately than many other medical disorders. R.L. Spitzer, J.B. Foreman, and J. Nee, “Field Trials for Inter-Rater Diagnostic Reliability”, *136 American Journal of Psychiatry*, 6815 (1979).

In this case, no one disputes the fact that Daniel Colwell suffers from a severe mental illness. No expert, on either side, has questioned the existence of Mr. Colwell’s severe mental illness. A close examination of Mr. Colwell’s history prior to and following the onset of his ten year struggle with schizoaffective disorder shows the devastating impact that his brain disorder has had on his ability to function and maintain his grip on reality. In the words of Professor Slobogin:

... people proven to be psychotic at the time of the offense are at least as volitionally and cognitively impaired at that crucial moment as are children and people with mental retardation who commit crimes. If anything, the delusions, command hallucinations, and disoriented thought process of those who are mentally ill represent greater dysfunction than that experienced by most “mildly” retarded individuals (the only retarded people likely to commit crime) and by virtually any non-mentally ill teenager.

Id. at 669.

In sum, it is scientifically unfounded and fundamentally unjust to prohibit the execution of people with mental retardation on one hand and fail to seriously weigh Mr. Colwell’s serious mental illness as a mitigating factor in his death sentence on the other.

2. Schizoaffective Disorder, A Serious And Chronic Brain Disorder.

The extensive factual record presented to the sentencing hearing jury revealed that Daniel Colwell was diagnosed with a variety of psychiatric disorders during his early years of treatment, including Paranoid Schizophrenia, Schizofreniform Disorder, Delusional (Paranoid) Disorder, and Grandiose and Schizoid Personality Disorder.⁶ The descriptions of his symptoms and behaviors by mental health professionals who treated

⁶ Testimony of Dr. Karen Bailey-Smith at Mr. Colwell’s sentencing hearing, Appellant’s Brief at 67.

him over the years were fairly uniform – paranoia, delusions, auditory hallucinations, and depression.⁷ Over time, psychiatrists and psychologists involved in treating Mr. Colwell have agreed on his diagnosis – Schizoaffective Disorder.

The 1990's saw significant advances in the neurosciences and these advances led to increased understanding about the pathophysiology of severe mental illnesses such as schizophrenia, schizoaffective disorder and bipolar disorder. Scientists are today in virtual agreement that these illnesses are brain disorders, more closely analogous to neurological disorders such as Epilepsy, Tourette's Syndrome and Alzheimer's Disease than they are to the mental health problems that affect many people in their daily lives. E. Fuller Torrey, Surviving Schizophrenia, 142 (third edition, 1995). In fact, scanning technologies such as Magnetic Resonance Imaging (MRI) have enabled scientists conducting twin studies to produce pictures showing dramatic differences in the brains of individuals with and without schizophrenia. (See Appendix 1).

Individuals diagnosed with schizoaffective disorder exhibit both psychotic symptoms characteristic of Schizophrenia and mood disturbances characteristic of major affective disorders, i.e. unipolar depression or bipolar disorder (manic-depressive illness). Allan Tasman, Jeffrey Kay and Jeffrey Lieberman, *Psychiatry*, Volume 2, pp. 948-949 (1997). Schizoaffective disorders are very difficult to initially diagnose, requiring observation of patients over time. Because they are so complicated, misdiagnosis is common, particularly in the early stages of treatment. NAMI Fact-sheet on Schizoaffective Disorder at 1 (attached as Appendix 2).

While schizophrenia and schizoaffective disorder are distinct diagnoses, the treatment of these disorders is virtually identical with the same anti-psychotic

⁷ See generally Appellant's Brief, pp. 4 – 67.

medications being used in both cases. Torrey, Surviving Schizophrenia, Id. at 91. In addition to anti-psychotic medications⁸, psychiatrists often treat people diagnosed with schizoaffective disorder with a mood stabilizer, such as Lithium or Depakote. NAMI Factsheet on Schizoaffective Disorder, pp. 1-2.

Severe mental illnesses such as schizoaffective disorder, schizophrenia, and bipolar disorder are chronic illnesses. Individuals who suffer from them may experience periods when their symptoms are in remission, but they are not curable. Individuals like Daniel Colwell require intensive services and supports over extended periods of time in order to maintain stability and to function effectively in society. Assertive community treatment and continuous treatment programs utilizing multi-disciplinary teams to provide comprehensive services and supports to people with mental illnesses have been highly successful in reducing jail recidivism, inpatient hospital stays, homelessness and other outgrowths of lack of treatment. See, e.g., Jack E. Scott and Lisa B. Dixon, Assertive Community Treatment and Case Management for Schizophrenia, 21(4) *Schizophrenia Bulletin* 657,664 (1995); Erik L. Goldman, Program Reduces Jail Recidivism for Mentally Ill, *Clinical Psychiatry News*, December 1996, at 26.

Unfortunately, the failure to provide individuals like Daniel Colwell with appropriate services and supports can have devastating consequences, including homelessness, suicides and, in some cases, violence. While the overwhelming majority of people with schizophrenia, schizoaffective disorder and other severe mental illnesses are not violent, there is a small subset of individuals who may engage in acts of violence towards themselves or others if not appropriately treated.

⁸ Antipsychotic medications include both older medications such as Thorazine, Haldol and Prolixin and newer, atypical antipsychotics such as Clozaril, Risperdol and Zyprexa.

Studies have shown that people with mental illnesses, when treated, are no more violent than the rest of the population. But, these studies have also demonstrated that lack of treatment or inappropriate treatment does increase the risk of violence. For example, a three site study recently funded by the MacArthur Foundation on violence and mental illness demonstrated that 17.4 % of psychiatric patients studied were violent in the 10 week period prior to hospitalization, during which time they generally were not being treated, compared to an average of 8.9% for the five 10-week periods after hospitalization during which time most individuals were being treated. Henry Steadman, Edward Mulvey, John Monahan, et al, “Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods”, *Archives of General Psychiatry* 55:393-401, 1998. See, also, Marvin Swartz, John Swanson, Virginia Hiday, et al, “Violence and Severe Mental Illness, *American Journal of Psychiatry*, 155:226-231, 1998; “(substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk).”

Daniel Colwell’s increasingly bizarre behaviors over a period of ten years demonstrated that he needed more than periodic injections of medication to maintain his psychiatric stability. At Southwestern State Hospital in Thomasville, where he was sent in August 1989 after the television station incident, the admitting physician observed Mr. Colwell as “paranoid, hyper verbal, suffering from religious delusions, threatening, agitated, sexually preoccupied, with loose associations.” Appellant’s Brief, at 41. In October, 1989, he was admitted on an emergency physician’s certificate who observed, inter alia, “overt homicidal ideations, secondary to admitted auditory hallucinations ... with some violent potential.” Id at 43. In 1992, the psychiatrist who treated Colwell in

the Georgia prison system observed that Colwell, in his severely mentally ill state, had “threatened to kill a human, such that he would get the electric chair.” Id. at 47. Later prison records revealed that he had stated to a counselor that he “wishes he had murdered someone so that he could be executed by the state.” Id. at 48. Surely, those responsible for treating him after his release from prison were on notice that this was an extremely ill individual who needed extensive services and supports and careful monitoring in the community.

3. The Record Shows That Daniel Colwell’s Condition Deteriorated In The Months Prior To The Crime.

Daniel Colwell’s psychiatric state was poor when he was released from prison in 1995 and it appears to have deteriorated further in the months preceding the death of Mr. and Mrs. Bell. His family became increasingly alarmed about his deteriorating condition. They tried to help by attempting to communicate with and obtain information from the mental health center that was responsible for his treatment. Unfortunately, the center’s staff apparently refused to communicate with the family, citing confidentiality. Appellant’s Brief at 50. Clearly, his family was in the best position to see his psychiatric deterioration and wanted to get him help. But, they were written out of the picture by treatment providers who should have known better, based on Colwell’s past history.

Questions must also be raised concerning whether Colwell received adequate treatment during this period. It appears that his treatment consisted of periodic injections of Prolixin. Presumably, he was being treated with this older psychotropic medication rather than one of the newer, frequently more effective atypical anti-psychotic

medications, because it was felt that he would not take medication regularly on his own.⁹ However, his demeanor and behaviors during this period strongly suggest that he was sinking into a deep, possibly psychotic depression. Despite this, there are no indications in the record that he was prescribed any medications to regulate his mood and severe depression. As with all medical illnesses, not all individuals diagnosed with severe mental illnesses respond equally well to particular treatments. Therefore, while it appears that Daniel Colwell showed up regularly for his Prolixin injections, the question remains whether this treatment plan was at all effective for him.

Additionally, while pharmacological interventions for severe mental illnesses are frequently the cornerstone of treatment, they are not enough. Daniel Colwell clearly required an intensive, assertive community treatment program that provided medication management, intensive case management, counseling, employment assistance and other services. There are no indications in the record that he was provided with anything other than periodic injections of medication. In between these injections, he was apparently allowed to sink deeper and deeper into a psychotic depression that ultimately led to tragic consequences.

4. Daniel Colwell demonstrated no propensity for violence prior to the onset of his severe mental illness. It is highly unlikely that he would have killed the two victims in this case were he not suffering from a severe mental illness.

Daniel Colwell is not a killer by nature, nor does he have a propensity for criminal behavior. The record demonstrates that he was never arrested or in any trouble with the law before the onset of his brain disorder. People who knew him as a child and as a high school student universally described him as a good person who came from a good family,

⁹ Only older antipsychotic medications such as Prolixin and Haldol were available in “depot” (i.e. injectible form) during this period.

worked hard, and never got into any trouble.¹⁰ He similarly earned respect, performed exceptionally well and avoided trouble during his four years as a football star at two separate colleges.

All three of Daniel Colwell's encounters with the criminal justice system can be directly attributed to the symptoms of his severe mental illness. His first arrest, for attempting to take over an Albany television studio to "broadcast his protest against Christianity", occurred in 1989 at a time when he was described as "paranoid" and "suffering from religious delusions."¹¹ This event precipitated several lengthy hospitalizations and the written opinion of a psychiatrist treating him that his prognosis was "guarded."¹² Clearly, Daniel's irrational behavior in attempting to take over the television station was not the product of a criminal mind but rather the product of a seriously mentally disturbed and psychotic individual.

Daniel Colwell's second arrest occurred in 1992 when he devised a plan to kidnap Millard Fuller, founder and president of Habitat for Humanity, apparently to exchange Fuller for pills that he could then use to commit suicide. Although Colwell was found competent to stand trial on the charges against him, the psychologist who evaluated him at West Central Georgia Regional Hospital recommended that he be found guilty but mentally ill, opining that "incarceration would only serve to worsen Mr. Colwell's

¹⁰ See, e.g., testimony of Daniel's High School friend and police officer, Charlie Pines, who stated that he had never known the teenaged Daniel Colwell "to get into any trouble. If he could do anything to help you, he would." Charlie Pines testimony, SH vii, 1992-1995, cited in Appellant's Brief at 25; testimony of Daniel's High School teacher, Betty Boys, who stated that other teachers in the school told her that "if you had a Colwell in your class, you had a good student, because he came from a family of caring people...And I knew that in my dealings with Daniel I never had any reason to doubt that that was true." SH vii, 1877, cited in Appellant's Brief, at 26; testimony of High School teacher Teresa Mansfield who characterized Daniel Colwell as "pensive, quiet, very industrious...the type of student that all teachers would love to have"...and "just a great guy." SH vii, 1998, cited in Appellant's Brief at 26.

¹¹ Appellant's Brief at 41.

¹² Id at 42.

condition.”¹³ Here again, the plan of Daniel Colwell to kidnap Millard Fuller was not the action of a malicious or depraved individual but rather a severely mentally impaired person in the throes of delusional thinking.

Finally, Daniel Colwell’s third and final arrest, for shooting and killing Mr. and Mrs. Bell, was again the product of an act committed by an individual who was in the throes of severe psychosis. This seemingly senseless act was the tragic culmination of a steady pattern of paranoid and delusional thinking and psychiatric deterioration over a period of ten years. Daniel Colwell did not know his victims, nor did he bear any particular animus towards them. He had convinced himself, in his highly delusional and psychotic state, that killing a white couple was the only way that he could accomplish his objective of state assisted suicide. His friend, Louis Chambliss, testified that Colwell had been experiencing and communicating suicidal thoughts for at least six years.¹⁴ Chambliss spent the night before the tragedy with Colwell who, according to Chambliss, kept repeating over and over again that “I just can’t keep going on like this.”¹⁵

Daniel Colwell’s psychiatric condition during the period of more than two years that occurred between the time of his arrest and the time of his sentencing is further illustration of the severity of his mental illness. By June, 1997, he had deteriorated so markedly in jail that he was admitted on an emergency basis to the Binion Unit at Central State Hospital. He remained at Binion for about one month, then was re-ordered back to the Binion Unit in November, 1997, where he remained until October, 1998, when he

¹³ Court ordered competency evaluation of Dr. Donald Grigson, October 21, 1992, SH xiii, 1336-1337, cited in Appellant’s Brief at 46.

¹⁴ Appellant’s Brief at 54.

¹⁵ Id.

was sentenced.¹⁶ Five experts (all of whom were psychiatrists or psychologists) testified at a hearing to determine Colwell's competency to stand trial that took place in April, 1999. While Colwell was ultimately determined competent to stand trial, all five of these experts agreed (a) that he suffered from a severe mental illness, and (b) that his illness had a profound effect on his emotional and cognitive states.¹⁷

Finally, Daniel Colwell's behavior at his trial and sentencing hearing are dramatic testimony to his impaired mental state. He insisted that he wanted the District Attorney to represent him, claiming that he and the D.A. shared common objectives (i.e. imposition of the death penalty). His repeated insistence that he wanted a death sentence was not the product of a rational mind but rather the delusional thinking of a very sick individual who saw state assisted suicide as the only way to escape his torment.

5. Carrying Out The Death Sentence In This Case Would Be Tantamount To State Assisted Suicide.

Tragically, at least 10,000 people with schizophrenia and bipolar disorder commit suicide each year in the United States. Treatment Advocacy Center Briefing Paper, "Suicide Among Individuals with Schizophrenia and Manic-Depressive Illness, 1 (Arlington, Va., 2001). A 1992 survey revealed that 19% of all people with schizophrenia had threatened or attempted suicide within the previous year. D.M. Steinwachs, et. al., "Family Perspectives on Meeting the Need for Care of Severely Mentally Ill Relatives: A National Survey", Johns Hopkins University School of Public Health (1992). The rates for people with bipolar disorder are even higher, F.K. Goodwin and K.R. Jamison, Manic-Depressive Illness, 230 (1990), (between 25% and 50% of all

¹⁶ Id. at 2.

¹⁷ See testimony of defense experts at Mr. Colwell's competency hearing summarized on pp. 6-19 of Appellant's Brief.

people with manic-depressive illness attempt suicide at least once, approximately 15% actually commit suicide).

The record is clear that Daniel Colwell was preoccupied with committing suicide for many years prior to killing Mitchell and Judith Bell. His delusional plan to kidnap Millard Fuller was based on his desire to commit suicide. He repeatedly expressed his desire and intent to force the state to kill him while in prison for this crime. See Appellant's Brief, pp. 47-48. It appears, based on the testimony of his friend, Louis Chambliss, that his suicidal ideation increased in the days leading up to the tragedy.

In some cases, individuals in the throes of severe mental illnesses carry out their suicidal wishes in bizarre ways. For example, the phenomenon known as "suicide by cop" describes a situation "whereby the suicidal subject engages in a consciously life-threatening behavior to the degree that it compels a police officer to respond with deadly force." Rebecca Stincelli, "Suicide by Cop: The Long Road Back", www.suicidebycop.com, 1 (2001).

Daniel Colwell undertook his senseless plan with the hope that it would force the state to help him do what he could not do himself – commit suicide. If the state of Georgia carries through with executing Mr. Colwell, it will, in effect, assist him in committing suicide. This is contrary to Georgia law which has enacted a statute making it a felony for anyone to actively assist in the suicide of another individual. O.C.G.A. § 16-5-5.¹⁸ Killing Mitchell and Judith Bell was the senseless, delusional act of a psychotic individual in the throes of severe mental illness. The State should not compound this tragedy by assisting Mr. Colwell to make his bizarre and deluded plan a reality.

¹⁸ See Appellant's Brief, pp. 149-150.

Conclusion

It may be difficult to feel sympathy for an individual who kills two innocent victims to carry out his own suicide. The killing of the Bells was a terrible tragedy and the pain that their surviving family members and friends must feel is unimaginable. Yet, the mark of a civilized society is to show mercy for those who are helpless or so impaired by illness that they are unable to act rationally on their own behalf. Daniel Colwell's actions in killing Mitchell and Judith Bell were not the act of an evil, cold blooded killer but rather the act of a very ill, severely mentally impaired individual. For the reasons set forth in this brief, and in the interests of justice, the death sentence imposed on Daniel Colwell in this case should be commuted to life without parole.

Respectively Submitted,

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